

Criminalising addiction: is there another way?

Report on the
CityWide conference

See pages 7–11.

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Coolmine marks 40 years in addiction services

Coolmine Therapeutic Community in Co Dublin celebrated 40 years in service delivery on Friday 17 May. A commemorative event was held at Coolmine Lodge to mark the occasion and a book aptly entitled *40 years helping people find their way home* was launched, which includes a collection of stories from past Coolmine clients. Established in 1973, Coolmine was the first specialist drug treatment centre of its kind in the country.

Coolmine's mission is to provide a range of quality community and residential services to empower people to end their dependence on drugs and alcohol. The continuum of care services range from detoxification through to lifelong aftercare, and include: outreach services; drop in services (where clients contemplating a drug free life can initially seek help/advice); stabilisation programmes; day programmes; residential programmes (including the only mother and child residential programme in the country); educational programmes; and community employment.

The treatment approach is based on peer support, in which drug-free participants, who live in small, structured, drug-free housing, are expected to contribute to the general running of the community and to their own recovery by actively taking part in educational activities and in group and individual therapy sessions.

Following some emotive and inspiring stories from current and past clients of Coolmine, CEO Pauline McKeown gave a brief overview of the community's vision and goals. She said that Coolmine currently provides a range of addiction treatment services to approximately 1,000 people each year. Ms McKeown highlighted some recent changes in the type of clients presenting to the centre, namely the increasing age profile (majority are in their thirties) and the move from predominantly Dublin admissions to over 50% of all admissions now coming from outside the capital. She also pointed to trends away from use of single opiates to polydrug use, and to a growth in the numbers taking cocaine, crack, and benzodiazepine.

The event was attended by President Michael D Higgins, who held the large audience captive with his praise for the services offered by Coolmine over the past 40 years. In particular, he mentioned the knock-on effects of addiction on families and friends, who he said were also beneficiaries of the success achieved through Coolmine's programmes. He reiterated the importance of Coolmine's work in providing a safe haven for people with addictions, who he felt generally get very little sympathy from the wider society. Also in attendance were founder Lord Paddy Rossmore and the children of the other founders, Jackie Ballard and Brian Delaney. Special guest speaker for the graduation was Mr Rowdy Yates, Senior Research Fellow at the University of Stirling.

The event culminated with a tour of the facilities and the graduation of the most recent clients to successfully complete Coolmine's programme.

(Caraíosa Kelly)



President Michael D Higgins with Coolmine Chairman Brian Ward and CEO Pauline McKeown at the 40-year celebratory event.

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Responding to addiction in a time of recession – BYAP seminar



On 24 June 2013 the Ballymun Youth Action Project (BYAP) hosted a seminar on responding to addiction in a time of recession. The purpose of the seminar was to provide an opportunity to step back and think about the experience of the impact of funding cutbacks, and the implications for this particular sector. Róisín Shortall TD described the seminar as providing a 'critical space' to reflect on what amounts to a slow dismantling of the safety net that has been created within local communities, leading to the re-marginalisation of particular areas.

The seminar was attended by over 80 representatives of community and voluntary agencies, funders, local people and political representatives. There were two speakers – Brian Harvey, an independent social research consultant, and Dr Mary Ellen McCann, lecturer in UCD's School of Applied Social Science and former director of Ballymun Youth Action Project.

Dermot King, executive director of BYAP, outlines the key themes that emerged at the seminar.

Brian Harvey, having outlined the scale of the withdrawal of resources from community-led responses to poverty and social inclusion, particularly since 2002, echoed the sense among those present that no one could have anticipated the wave of destruction of our social, community development infrastructure that we are experiencing, when Ireland was previously seen as a European leader in this regard. He outlined what he termed a 'strategic turn' which began in 2002 and which was compounded by the 2008 economic and social crisis. Against a baseline figure of a 4.3% cut in government spending overall between 2008 and 2013, local and community development programmes have been cut by 42%, and the Drugs Initiative

by 32%. It is estimated that by 2015, there will be 31% fewer workers in the voluntary and community sector. Mr Harvey added that no other country in Europe, so far as we know, has experienced such an extraordinary decline since 1948.

Dr Mary Ellen McCann illustrated the intimate connection between community issues and drug problems, and how policies in either domain have large effects in other domains. In the context of competing consultancy reports, the call for 'evidence' needs to take account of a range of more subtle measures, including case studies which provide rich data to increase our understanding, and the utilisation of community indicators that allow access to a range of measures regarding what is really important for communities affected by drug use. She stressed that, in the context of the narrative of the development of community responses, the community needs to tell the community story.

Underlying the recognition of the current crisis and its origins, contributors were clearly wary of the talk of a straightforward recovery, where 'all will be well again'. Instead, the speakers raised the real concern of 'cost cutting' becoming 'penny pinching' in the name of 'reform', and the growing hints of 'post-austerity austerity'.

A clear message was given regarding the importance of holding on to the developments within the sector that have been achieved over the last 30 years, and the 'footholds that have been gained' in the creation of community responses and systems. The response within the voluntary and community sector must endure and, as Mr Harvey concluded, 'It behoves us to make the case for an enlightened balanced European social model, with a role for civil society'.

(Brigid Pike and Dermot King)

BYAP values individuality and people's potential for change

Founded in 1981, the Ballymun Youth Action Project (BYAP) is a community-based response to drug and alcohol misuse. It works with individuals, supports families and communities, and builds capacity through training and research. At its seminar on austerity, described in a separate item in this issue of *Drugnet Ireland*, BYAP invited Róisín Shortall TD, former Minister of State with responsibility for drugs, to launch its annual report for 2012 and its strategic plan for 2013–2015.¹

In 2012 BYAP provided services to well over 1,000 people, as the following selection from the annual report shows.

Service provided, 2012	Number of recipients/participants
Individual services, ranging from contact services delivered to those not engaged with services, through day programmes, counselling, family services, complimentary services, to aftercare services for those in recovery	567
Schools Drug and Alcohol Awareness Programme, delivered in five local primary schools	230
Boxing Clever Programme	22
Drug Treatment Programme in Mountjoy Prison	72
URRUS (Education and Training Services)	550
URRUS (Education and Training Services)	300
Source: <i>BYAP Annual report 2012</i>	

BYAP also collaborated with other local groups in the delivery of services, including the Ballymun Educational Support Team (BEST), the Ballymun Regional Youth Resource (BRYP), Youthreach Ballymun, and the Community and Family Training Agency (CAFTA).

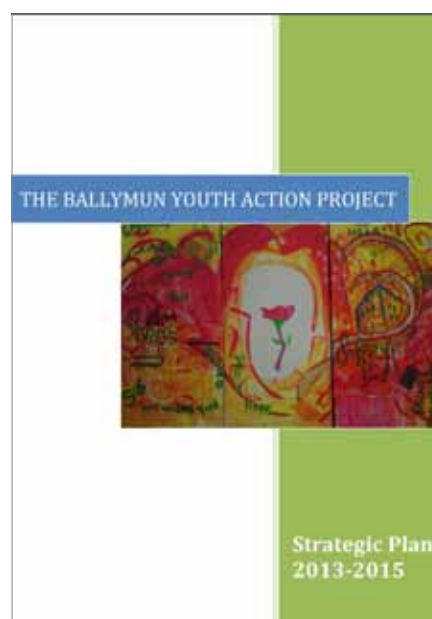
In 2012 BYAP lost its funding from the City of Dublin Youth Services Board (CDYSB),² which opted to redirect funds to 'mainstream youth services', and had to make two staff members redundant and reduce the working hours of 10 others as a direct result of cutbacks. However, BYAP continued to evolve to meet local needs, becoming part of the Community Detox Pilot Programme, participating in the Network for Assisting Children and Young People (NACYP), and creating a new position of 'infant parent support worker', which is funded by the Ballymun LDTE. The aim of this new role is to meet the needs of children and parents where there are issues related to problem drug and/or alcohol use in the infant stages of the child's life. Finally, in 2012 BYAP began using the eCASS (electronic Consolidated Automated Support System) data system and reported that it became much easier to monitor and report on work done. It plans to develop eCASS further in the coming years, to maximise effectiveness of interventions and capture outcomes.

In its strategic plan for 2013–2015, BYAP sets out its way of working. Its approach is rooted in an ethos of valuing individuality and the capacity of individuals, families and communities. It commits to:

- respecting where people have come from, where they are at now, and where they see they could be;
- supporting the possibility of change; and
- addressing where necessary the bigger issues that are presented by the many cross-cutting systems within which each individual has to make their way in life, including their family, the education system, the justice system, and the health system.

These values and commitments are reflected in the three strategic objectives and actions that BYAP has set for the next three years, which are summarised in the table on the following page.

(Brigid Pike)



BYAP values individuality (*continued*)

Strategic objectives, 2013–2015	Outline of actions
1. To provide a continuum of service which meets people where they are at, provides a range of treatment and rehabilitation pathways that are flexible and effective, and which works in conjunction with the range of other services locally.	<ul style="list-style-type: none"> - Communicate BYAP's vision to all stakeholders to maximise positive outcomes - Establish BYAP's role as a provider within the developing profile of addiction services in Dublin North-East - Roll out an interagency data sharing system in partnership with the Ballymun LDTF
2. To identify emerging trends within drug and alcohol use, and to develop appropriate responses	<ul style="list-style-type: none"> - Develop services for young people through engaging with young polydrug users, and engaging with the NACYP - Promote a detailed presentation of BYAP services for young people with drug and alcohol issues - Engage with Dept of Justice as it expands initiatives supporting reintegration of prisoners into the community - Promote a detailed presentation of BYAP services for family members affected by drug or alcohol use
3. To promote and acknowledge change as an integral part of the response to drug and alcohol use	<ul style="list-style-type: none"> - Review the needs of the ageing opiate-using population who are currently using BYAP services - Develop new treatment/rehabilitation interventions for this population at individual and group level - Develop and deliver specific programmes that respond to change-related challenges facing service users

Source: *BYAP Strategic plan 2013–2015*

1. Ballymun Youth Action Project (2013) *Annual report 2012*. Dublin: The Ballymun Youth Action Project Ltd, and Ballymun Youth Action Project (2013) *Strategic plan 2013–2015*. Dublin: The Ballymun Youth Action Project Ltd. www.drugsandalcohol.ie/20081
2. The CDYSB is the youth development agency of the City of Dublin Education and Training Board (CDETb), formerly the City of Dublin Vocational Education Committee.

The following article was one of the final pieces of work written by Dr Justine Horgan, Senior Research Officer at the National Advisory Committee on Drugs and Alcohol.

It is with both pride in her accomplishments and regret at her untimely passing that we publish the article now.

'Ar dheis Dé go raibh a h-anam dílis'

Colleagues in the NACDA

Extent and patterns of cannabis use in Ireland

The National Advisory Committee on Drugs and Alcohol (NACDA) recently published Bulletin 3 in the series of reports on the 2010/11 survey on drug use in the general population in Ireland and Northern Ireland.¹ The bulletin reports on cannabis use in the adult population (15–64 years), on cannabis dependence and cannabis abuse as well as on patterns of cannabis use in Ireland. A total of 5,128 people were interviewed, representing a response rate of 60%. This article presents a summary of the main results for Ireland reported in the bulletin.

Key findings

Prevalence: use, abuse and dependence

The results from the 2010/11 survey reveal that 25% of the adult population (15–64 yrs) reported having used cannabis at some point during their lives (lifetime use); 6% reported use in the year prior to the survey (recent use); 3% reported use in the month prior to the survey (current use).

The rates of cannabis use were notably higher among men than women. Lifetime prevalence for men (33%) was almost twice as high as the rate for women (18%); last-year prevalence was three times as high (men, 9% vs women, 3%); and last-month prevalence was five times as high (5% vs 1%). The lifetime prevalence among men increased from 27% in the 2006/7 survey to 33% in the 2010/11 survey, a statistically significant increase of 22%. There was a relatively small increase, from 17% to 17.5%, in women's lifetime prevalence rates in the same period.

Rates of cannabis use were substantially higher among young adults (15–34 years) than among older adults (35–64 years) in the 2010/11 survey. Lifetime prevalence among young adults (33%) was more than one and a half times that among older adults (19%), last-year prevalence was just over three times as high (young adults 10% vs older adults 3%) and last-month prevalence was five times as high (5% vs 1%). While there were statistically significant increases in lifetime prevalence for younger adults, from 29% in 2006/7 to 33% in 2010/11, no statistically significant changes were found for older adults over that period (3% in both 2006/7 and 2010/11).

The prevalence of cannabis **abuse** and of cannabis **dependence** were measured in the NACD Drug Prevalence Survey the first time in 2010/11 using M-CIDI,² as advised by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Substance abuse and substance dependence are defined by the DSM-IV as a maladaptive pattern of substance use leading to clinically significant impairment or distress.

Seventeen per cent of recent cannabis users met the criteria for cannabis abuse, with rates being higher among males (20%) than females (8%) and among young adults (20%) than older adults (9%). Of the valid responses from the survey sample, 1.3% met the criteria for current cannabis abuse. Applying this rate to the 15–64-year-old general population (3,073,269 in 2011) we can infer that approximately 39,953 people in Ireland abuse cannabis.

Nine per cent of recent cannabis users were classified as dependent. Dependence was higher among males and among young adults. Of the valid responses from the survey sample, 0.6% met the criteria for current cannabis dependence. Applying this rate to the 15–64-year-old general population, we can infer that approximately 18,440 people in Ireland are cannabis dependent.

Patterns of cannabis use

Among lifetime cannabis users, the median age of first use was 18 years. This was unchanged since the last survey.

Almost half (48%) of the current cannabis users had used cannabis on 1–3 days (lowest frequency use) in the month prior to the survey, an increase on the 2006/7 figure of 37%; this frequency was most common among female users (54%) and older adult users (55%). Between the two surveys the proportion of all adults engaging in the highest frequency use (20 days or more) in the previous month decreased from 24% to 14%.

Since 2006/7 the relative share of herb to resin used by current users has reversed. In 2010/11 herb was the main type of cannabis used by current users, at 71%, while resin, at 60%, was the most common form reported in the 2006/7 survey. Almost all (94%) current cannabis users said that a joint was the main method they used when consuming cannabis. Forty-five per cent did not know where the cannabis they consumed was grown; 38% said that the cannabis they used was grown in Ireland, an increase on the 2006/7 figure of 16%.

Nearly three quarters (73%) of recent users said it would be easy for them to obtain cannabis in a given 24-hour period. Over four fifths (83%) said they sourced cannabis from someone they knew relatively well, e.g. either shared by or bought from family members and/or friends.

Over one quarter (27%) of lifetime cannabis users said they had used it on a regular basis at some point and most (74%) of this group said they had stopped using. The three most common reasons given for stopping cannabis use were: not wanting to take it any more (27%); cannabis being no longer a part of their social life (18%); and health concerns (17%).

Extent and patterns of cannabis use in Ireland (*continued*)

Acceptability of cannabis use

Respondents were asked about the acceptability and risk of cannabis use:

- 66% agreed with cannabis use being permitted for medical reasons;
- 69% disagreed with cannabis use being permitted for recreational reasons;
- 73% disapproved of smoking cannabis occasionally;
- 64% considered smoking cannabis on a regular basis to be very risky.

Profile of cannabis users in Ireland

Socio-economic group: Rates for lifetime cannabis use were highest among those classified as Group A (professionals and managers) (35%) and lowest among those in Group D (semi-skilled and un-skilled) (20%). Last-year rates were also highest for those in Group A (10%) and lowest among those in Group C2 (skilled manual workers) (7%).

Housing tenure: Cannabis prevalence rates were highest among people renting accommodation. Among those renting from a private landlord, the lifetime prevalence rate was 37%, and last-year prevalence was 12%. Rates for last-month use were highest among those renting from a local authority/housing agency (7%).

Level of education and age left school: Results point to cannabis use increasing with level of education attained. On the one hand, rates were highest among students, at 21% (lifetime), 10% (last-year) and 4% (last-month). Lifetime rates were also highest among those who had left school at 20 years or over (34%) and among those with a third-level education (31%). On the other hand, lowest lifetime rates were found for those who left school at 15 years or under and among those with primary-level education only (19%).

Marital status: Last-year prevalence was highest among those who were cohabiting (13%), followed by those who were single (12%). Last-month rates were highest among cohabiting and divorced people (at 7%).

Discussion

The findings of the 2010/11 survey suggest a mixed picture regarding the cannabis situation in the general population in Ireland. More people than ever before had tried cannabis at least once in their lifetime, with the rate at one in four adults, compared to one in six in the 2002/3 survey. The trend is, however, changing and rates for last-year and last-month prevalence have tapered off since the last survey. This development is in line with that in many European countries which are reporting a recent fall or stabilisation in cannabis prevalence rates.³ Additionally, among those consuming cannabis, age of initial use has remained the same, a welcome finding given the link between early initiation and high-risk groups.

The 2010/11 survey data show that age continues to be an important factor in the pattern of cannabis use in Ireland and that use declines with age. Gender is also important for several reasons: it interacts with age with the effect that the decline in use happens later for men than for women. Although the extent of use has declined, prevalence rates are still considerably higher among men than women, with no indication of any narrowing of the gender gap. Closer examination of the data is needed, however, as these age and gender effects are likely to vary across regions in Ireland, reflecting differences in context, particularly social and economic circumstances. These influences, how they vary with context and time are important, particularly for

targeting areas where patterns of drug use have become entrenched and for identifying where action may be needed to prevent this situation.

When compared to results from the 2006/7 survey, cannabis is now used less frequently among current users, an important finding given the increased uptake of herbal cannabis use since the last survey. While the data from the two surveys show that high-frequency use has always been more common among men than women, the propensity for men to be high-frequency users has fallen sharply since the 2006/7 survey, with the effect that the gap between men and women has reduced considerably between the two time periods.

The likelihood of a young adult in Ireland using cannabis daily or almost daily has declined substantially since the survey in 2006/7. Despite lower prevalence, frequency of use is higher among older adults, changing little since the last survey. Among current users, high-frequency use, or intensive use, is reported by 10% of young adults and 24% of older adults.

An indication of the public health impact of a drug can be seen in the numbers entering treatment. The number of treatment cases reporting cannabis as their main problem substance has increased significantly in Ireland and in 2010 cannabis became the most common problem drug reported by new cases.⁴

Dependence is increasingly recognised as a possible consequence of regular cannabis use. For many people, intensive use and dependence on cannabis are linked. Among those defined as recent users, 17% met the EMCDDA criteria for cannabis abuse and 9% were classified as dependent.

However, in comparison with the available data on tobacco or alcohol use, little is known about the extent of cannabis dependence or abuse in Ireland. This bulletin provides a solid baseline for the ongoing monitoring of the prevalence and nature of cannabis dependence and abuse in the general population and among recent users. Its findings also point to the need for further research on the consequences of increased availability of high-potency cannabis, on the experiences of cannabis use in the population of long-term users, and on the continuation and discontinuation rates of long-term use and factors influencing these rates and how these might be targeted by treatment and other services.

(Justine Horgan)

1. National Advisory Committee on Drugs (2013) *Drug use in Ireland and Northern Ireland. 2010/11 Drug prevalence survey: cannabis results*. Bulletin 3. Dublin: Stationery Office. www.drugsandalcohol.ie/20139
2. The Composite International Diagnostic Interview (CIDI, World Health Organization, 1990) contains the DSM-IV diagnostic criteria for substance abuse and dependence and is a validated method to assess the seriousness of a person's cannabis use. On the advice of the EMCDDA, the abbreviated version, the Munich Composite International Diagnostic Interview (M-CIDI), a 19-item instrument reflecting the four cannabis abuse and seven cannabis dependence criteria, was used for the NACD 2010/11 Drug Prevalence Survey.
3. EMCDDA (2011) *Annual report 2011: the state of the drugs problem in Europe*. Luxembourg: Publications Office of the European Union. www.drugsandalcohol.ie/16288
4. Bellerose D, Carew AM and Lyons S (2011) *Trends in treated problem drug use in Ireland 2005–2010*. HRB Trends Series 12. Dublin: Health Research Board. www.drugsandalcohol.ie/16381

Criminalising addiction: is there another way?

This was the title of a conference hosted by CityWide Drugs Crisis Campaign in Dublin on 21 May 2013. The objective was to start an evidence-based debate on Ireland's current drug policies and the alternatives.¹

Some 120 participants from community drug projects, voluntary projects, youth services, drugs task forces, government departments and universities attended the conference at which four speakers made presentations – Brigid Pike, Health Research Board (HRB); Liam Herrick, Irish Penal Reform Trust (IPRT); Johnny Connolly, HRB; and Niamh Eastwood, Release. Brief reports on these presentations are provided in the following pages.²

Following the presentations, participants took part in table discussions on the barriers to decriminalisation and what the international evidence tells us about the issue. There was general, but not complete, agreement that the evidence

for decriminalisation is convincing, while the issues around legalisation appear to be complicated. It was also noted that the underlying issues of poverty and social disadvantage remain crucial to addressing the impact of drugs on the lives of people, families and communities.

In closing the conference, the chairperson of CityWide, Anna Quigley, stated that the conference was a first step. CityWide plans further steps to promote the debate.

1. The conference was organised on foot of a commitment made by CityWide in 2012 to hold an open debate on decriminalisation. See Higgins M (2012) *The drugs crisis: a new agenda for action*. Dublin: CityWide. www.drugsandalcohol.ie/17145
2. A written report on the conference and videos of the four presentations are available at www.citywide.ie/news/2013/05/27

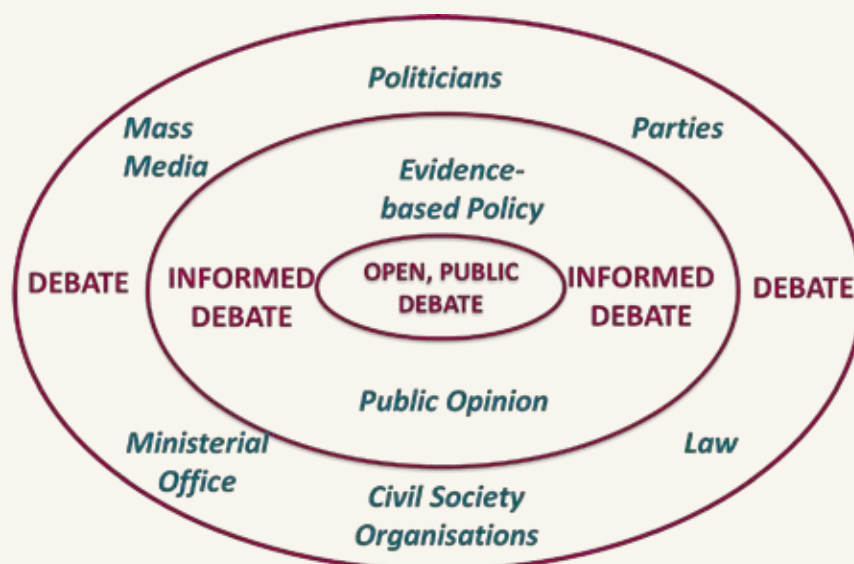
Breaking the taboo – debating the alternatives to criminalised addiction

The first presenter at the CityWide conference, Brigid Pike (HRB), described how calls have been coming thick and fast from around the world since 2009 to 'break the taboo' on debating alternatives to the international drug prohibition regime.¹

In December 2012 the UN General Assembly adopted a resolution to hold a Special Session (UNGASS) on the world drug problem in 2016. The sponsors of the resolution noted that

...despite continuing increased efforts by States, relevant organisations, civil society and non-governmental organisations, the world drug problem continues to constitute a serious threat to public health and safety and the well-being of humanity, in particular children and young people and their families, and to the national security and sovereignty of States, and that it undermines socioeconomic and political stability and sustainable development.

Posing the questions, what is Ireland's policy position going to be at this Special Session, how will it arrive at this position and how open will the process be, Pike proposed a model for thinking about democratic processes in relation to drug policy development (see graphic below). Drawing on the work of cultural sociologist Jeffery Alexander,² she suggested that a range of different actors need to participate fully to ensure open and public debate:



CityWide conference presentations (continued)

Politicians, civil society organisations, government ministers, political parties, policy advisers and officials, and the media all need to contribute to the debate. While there is evidence that individual politicians have become more open in recent years to exploring alternative responses to the illicit drug problem,³ there is room for a more systematic and concerted effort by all parties.

The debate needs to be informed by theory, research-based evidence and analysis of the consequences, risks and benefits of the various policy options. While Ireland has made enormous strides with regard to the collection of data on the extent and nature of drug misuse in Ireland, and on interventions, Pike noted that there has never been an evaluation of Ireland's national drugs strategy. An understanding of prevailing social, cultural and moral beliefs and attitudes is also important for ensuring that the chosen policies reflect the views of, and are acceptable to, the majority of citizens. Pike noted the last nationwide general population survey of knowledge, attitudes and beliefs regarding illicit drugs and drug use in Ireland was conducted over a decade ago.⁴

(Brigid Pike)

1. Latin American Commission on Drugs and Democracy (2009) *Drugs & democracy: toward a paradigm shift*. Accessed 28 September 2012 at www.drogasedemocracia.org ; Global Commission on Drug Policy (2011) *War on drugs: Report of the global commission on drug policy*. Accessed 28 September 2012 at www.globalcommissionondrugs.org ; House of Lords European Union Committee (2012) *The EU drugs strategy report. 26th report of session 2010–2012*. HL Paper 270. Accessed 28 September 2012 at www.parliament.uk/business/committees/committees-archive/lords-s-comm-f/eufwrevid/ ; Home Affairs Committee (2012). *Drugs: Breaking the Cycle. 9th Report of Session 2012–2013*. HC 184–I [incorporating HC 1774 of Session 2010–12. Accessed on 14 May 2013 at www.parliament.uk/business/committees/committees-a-z/commons-select/home-affairs-committee/publications/previous-sessions/session-2012-13
2. Alexander J (2008) *The civil sphere*. Oxford: Oxford University Press.
3. See Pike B (2012) Politicians and the drug debate – 6 years on. *Drugnet Ireland*, (41): 7–8. www.drugsandalcohol.ie/17272/
4. Bryan A, Moran R, Farrell E and O'Brien M (2000) *Drug-related knowledge, attitudes and beliefs in Ireland: report of a nation-wide survey*. Dublin: Health Research Board. www.drugsandalcohol.ie/5202/

Incarceration as a health strategy – imprisonment for drug offences in Ireland

Reviewing Ireland's history of using prison sentences, particularly medium- to long-term sentences, as its 'main tactic' in tackling the illicit drug market, and analysing trends in the prison population over the same period, Liam Herrick (IPRT), the second presenter at the CityWide conference, argued that the tactic had not been effective. He also showed that the policy approach is not based on any strong evidence.

In outlining the history of prohibition in Ireland, Herrick singled out two key 'moments' – (1) the Misuse of Drugs Act (MDA) 1977 which introduced a 14-year maximum sentence for distribution of illegal drugs, followed by the MDA 1984, which increased the maximum possible sentence to life, and (2) the Criminal Justice Act 1999 which inserted Section 15A in the MDA 1977, creating a mandatory minimum sentence of 10 years for the illegal distribution of controlled drugs over the value of €13,000. Herrick noted that in the 1980s and 1990s long sentences were consistently imposed on senior figures in the illegal drugs trade in Ireland. He went on to describe how this changed after the introduction of Section 15A in 1999, with long sentences being applied to minor figures in the drug trade on a large scale.

Looking at the size and profile of the Irish prison population from the 1960s onwards, Herrick noted that it had increased from less than 500 in 1960 to nearly 4,500 today, and that there was a particularly rapid increase in the first decade of the new century. He argued that this increase was partly due to the introduction of mandatory drug sentencing in 1999.

He pointed to two statistics supporting this assertion:

- Between 2005 and 2009, the number of charges brought by the gardaí in most categories, e.g. theft and burglary, remained static but drug supply offences doubled.
- Over the same period, the number of short-term sentences and life sentences remained stable but the number of 3–10-year sentences increased substantially. He linked this to an increase in the number of circuit court and high court prosecutions of drug offenders receiving 3–10 year sentences. Moreover, almost uniquely in the Irish sentencing regime, people convicted for medium-term sentences under the MDA, including Section 15A, are not eligible for temporary release or community return.

Almost uniquely in the Irish sentencing regime, people convicted under the MDA, including Section 15A, are not eligible for temporary release or community return. Herrick suggested this is another reason for the bulge in the number of prisoners serving medium-term sentences.

Who are these people getting Section 15A sentences of 3–10 years? Herrick described a sample study that IPRT did, using the Irish Sentencing Information System, to see how many of these prisoners were senior drug figures. The study found that:

- more than one third had no previous conviction,
- more than three-quarters had not been in prison before,

CityWide conference presentations (continued)

- more than one quarter had mental health problems,
- almost half suffered from alcohol addiction, and
- fewer than one in eight could be reasonably identified as being a senior figure in the drugs trade.

Given the profile of these offenders, Herrick pointed out that they are at a much lower risk of reoffending and should be eligible for temporary release or community return.

Herrick cited research from Australia,¹ the USA² and Ireland,³ which found that presumptive drug offence sentencing regimes were not effective in reducing levels of criminality. He noted that the UK, which also operates a presumptive sentencing regime, has recently moved to a more nuanced approach, requiring the type of drug involved and the person's role in the drug trade to be taken into consideration.⁴

Herrick concluded by proposing some 'modest ideas for reform within the criminalisation context':

- repeal Section 15A of the MDA 1977 completely,
- adjust the monetary amount upwards,
- amend the presumptive sentencing regime to refocus on the role played by the offender in the drugs trade and/or the substance involved, or
- allow for the structured temporary release of all prisoners serving presumptive sentences (including access to community return).

Even adopting the last three ideas would, Herrick suggested, have an immediate effect on the size of the Irish prison population and the problem of overcrowding. He observed that some 400 prisoners, 10% of the total prison population, who are currently serving 3–10-year sentences for drug dealing, are not senior figures in the drug trade and could be eligible for temporary release.

(Brigid Pike)

1. Law Institute of Victoria (2011) *Mandatory minimum sentencing*. Melbourne: Law Institute of Victoria. Available at www.liv.asn.au/getattachment/22c3c2c9-45a5-45c4-96e6-f0affdfe2ff8/Mandatory-Minimum-Sentencing.aspx
2. Caulkins JP, Rydell CP, Schwabe WL and Chiesa J (1997) *Mandatory minimum sentences: throwing away the key or the taxpayers' money?* MR-827-DPRC. Santa Monica, CA: Rand. Available at www.rand.org/pubs/monograph_reports/MR827.html
3. Law Reform Commission (2013) *Report: mandatory sentences*. LRC 108–2013. Dublin: LRC. Available at www.drugsandalcohol.ie/20242
4. Sentencing Council (2012) *Drug offences: definitive guideline*. London: The Sentencing Council for England and Wales. Available at [http://sentencingcouncil.judiciary.gov.uk/docs/Drug_Offences_Definitive_Guideline_\(web\).pdf](http://sentencingcouncil.judiciary.gov.uk/docs/Drug_Offences_Definitive_Guideline_(web).pdf)



Beyond criminalisation

The dominant paradigm for understanding the effects of drug laws is the rational choice perspective derived primarily from classical economic theory. This theory rests on the assumption that people are rational actors capable of evaluating the consequences of alternative choices. It also assumes that human behaviour is essentially hedonistic and motivated by the desire for pleasure and the avoidance of pain. The purpose of the criminal law is to make the punishment for criminal behaviour greater than the pleasure to be derived from it.

The distinctive features of deterrence were described by McLaughlin (2006)¹:

Deterrence requires three key elements:

- The certainty of apprehension, conviction and punishment.
- The severity of the punishment to be greater than the potential benefits of the criminal act.
- The clarity of punishment to ensure that the offender is in a position to make the link between her/his punishment and her/his criminal behaviour. (p.125)

When applied in the context of the decision to use illicit drugs, the rational choice perspective emphasises three factors that impact on decision-making: the drug's availability, the price of the drug and the risk of apprehension and punishment. Drug laws aim to restrict supply and availability, thereby increasing the price and discouraging use. Although drug policy and drug law enforcement rests heavily on deterrence theory, little research has been conducted in Ireland on its effectiveness in deterring drug use and drug dealing.

In the Irish context, O'Mahony (2008)² situates the Misuse of Drugs Act 1977 'at the heart of the prohibitionist system and the manner and effectiveness of its enforcement to a significant extent defines the reality of the Irish "war on drugs"' (p.68). The Act was introduced in the context of a relatively non-problematic drug scene in the mid-1970s, but one that would soon escalate. In the mid-1990s with the resurgence of the heroin crisis and, in particular, following the assassination of Veronica Guerin by people involved in the drug trade, a series of further quite draconian legislative measures were adopted, including the establishment of the Criminal Assets Bureau, enhanced Garda detention powers, restrictions to the bail laws, provisions to respond to organised crime and mandatory sentencing provisions in drug cases. This process of legislating in response to crisis has been described by many legal commentators as a form of legislation by 'moral panic'.³

When considering the impact of criminalisation it is important to move beyond the often heated rhetoric that can accompany debates about drug laws and the so-called 'war on drugs', and analyse how precisely the laws we have are actually implemented on a day-to-day basis by the Garda Síochána.

Figure 1 shows trends in prosecutions for the main drug offences of supply and possession between 1993 and 2005. It is clear from these data that the vast majority of drug offences prosecuted are for the simple possession of drugs for personal consumption, with seizure data showing that this is mostly cannabis-related.⁴ The large spike in such prosecutions between 1996 and 1998, it is suggested, was a consequence of the Veronica Guerin murder. Despite the intense political reaction to this event, it is apparent that

CityWide conference presentations (continued)

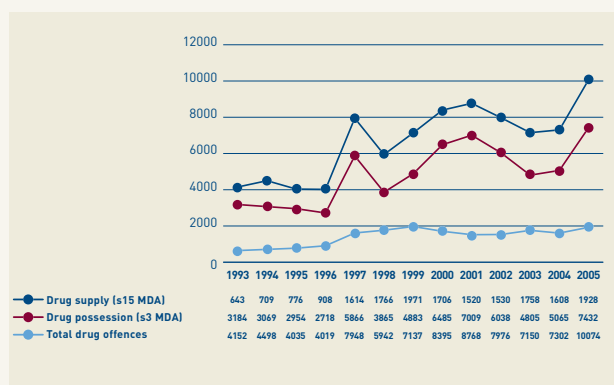


Figure 1 Trends in supply, possession and total drug offence prosecutions 1993–2005

Source: Annual reports of An Garda Síochána 1993–2005

actual drug law enforcement involved merely a sharp but temporary increase in simple cannabis possession charges, primarily as a consequence of routine Garda 'stop and search' activity, while supply offences increased only marginally.⁵

Furthermore, it is important to consider against whom such 'stop and search' powers are generally employed. The reality of day-to-day police work is that it involves a significant degree of discretion in terms of how and against whom police powers are typically directed. Research in other jurisdictions has shown how police 'stop and search' powers are often used disproportionately against ethnic minority and socially marginalised groups.⁶ Irish research in this area is limited. However, although a large number of middle-class people in Irish society regularly consume drugs, often on a recreational basis, the profile of the 'drug criminal', as reflected for example in those who end up imprisoned for drug-related crime, has remained consistent over time. They are typically young working-class males who left school early and are from areas with high levels of unemployment or they are 'drug mules' who perform relatively minor roles in the overall drug trade.⁷

The evidence suggests that drug availability and use and drug-related criminality appear to have been largely unaffected by the many new legal measures referred to above as illicit drug markets have penetrated more deeply into the fabric of many communities; these markets have become more diverse in terms of the drugs available, populated by ever-younger people and more violent. Meanwhile, drug prices have declined throughout Europe in recent decades. This is not to suggest that drug law enforcement has no value. As Roberts *et al.* (2005: 2) point out, 'failure to reduce prevalence does not mean that supply reduction initiatives (and, specifically, law enforcement) are having no impact on drug markets. It is widely – and reasonably – argued that supply reduction *contains* the expansion of drug markets, even if it fails to *reduce* markets.'⁸

However, the failure of prohibition/criminalisation to significantly reduce drug use and availability, the resilience and adaptability of illicit drug markets in the face of highly-resourced drug law enforcement, coupled with the often negative consequences of prohibition, has led to calls for a fundamental re-examination of the international system of drug prohibition. These calls have come from countries at all levels of the international drug trade – production, transit and consumption. Policy options advocated include

changes to the legal status of drugs, whether through direct legalisation or some form of decriminalisation, and a realignment of the balance between criminal justice and harm reduction approaches.

The recent 'head shop' phenomenon in Ireland should send a note of caution to advocates of drug legalisation in this country. The evidence from this experience suggests that legalisation in a free market economy would lead to an increase in experimentation and use by young people as a consequence of increased availability and aggressive marketing.⁹ A liberalisation of drug laws would also be counter to recent moves towards greater regulation in relation to tobacco and, increasingly, to the other principal mind-altering substance in Irish society, alcohol. Another question that advocates of legalisation need to address is: How will legalisation improve the situation in those communities where the sale and use of drugs have had the most pernicious effects?

On the other hand, there is evidence about the beneficial impact of decriminalisation, at least as it has been introduced in Portugal.¹⁰ The Portuguese experiment, which involves decriminalisation within the context of an overall harm-reduction approach, has led to a number of positive outcomes, including a large reduction in drug-related deaths. Although it initially led to a slight increase in drug use among some groups, this was not sustained over time. It now has broad political support, even from former opponents of the strategy.

(Johnny Connolly)

1. McLaughlin E (2006) Deterrence. In McLaughlin E and Muncie J (eds) *The SAGE dictionary of criminology*. 2nd edition. London: SAGE.
2. O'Mahony P (2008) *The Irish war on drugs: the seductive folly of prohibition*. Manchester: Manchester University Press.
3. Cohen S (1980) *Folk devils and moral panics: the creation of mods and rockers*. Oxford: Martin Robinson. For an Irish application of 'moral panic' theory see: Hamilton C (2005) Moral panic revisited: part 1. *Irish Criminal Law Journal*, 15(1): 8–12.
4. For further discussion of these data see: Connolly J (2005) *The illicit drug market in Ireland*. HRB Overview Series 2. Dublin: Health Research Board and Connolly J (2006) *Drugs and crime in Ireland*. HRB Overview Series 3. Dublin: Health Research Board.
5. It should be noted that the intelligence-led nature of supply level enforcement means that far more resources are involved in this police activity.
6. For a discussion see Reiner R (1997) Policing and the police. In Maguire M, Morgan R and Reiner R (eds) *The Oxford handbook of criminology*. 2nd edition. Oxford: Oxford University Press.
7. See article on mandatory sentencing on p. 32 of this issue.
8. Roberts M, Trace M and Klein A (2005) *Law enforcement and supply reduction*. Drugscope report for the Beckley Foundation Drug Policy Programme. Report 3. Oxford: Beckley Foundation. <http://reformdrugpolicy.com/library/>
9. Kelleher C, Christie R, Lalor K et al. (2011) *An overview of new psychoactive substances and the outlets supplying them*. Dublin: National Advisory Committee on Drugs.
10. Connolly J (2009) Report examines effects of decriminalisation of drugs in Portugal. *Drugnet Ireland*, (30): 22–23.

CityWide conference presentations (continued)

Global trends in decriminalisation

Decriminalising drug possession does not lead to any statistical increase in drug use. This was the key message of the final presenter at the CityWide conference, Niamh Eastwood, executive director of UK-based Release.¹ She spoke about a recent Release report on drug decriminalisation policies around the world.²

Decriminalisation means the removal of criminal sanctions for illegal drug possession. Release sees decriminalisation as being especially important because it means that individuals do not end up with a criminal record. Release argues that it is the criminal justice approach to drugs that has led to the greatest harms to individuals and to society: it has spawned generations of people isolated from mainstream society as a result of incarceration, issue avoidance, or the stigma attached to drug use.

Speaking to a map of the world, Eastwood highlighted the various approaches to decriminalisation in the 21 countries described in the report. She defined two main approaches to decriminalising drug use:

- *de jure*, based on legislation that removes the criminal sanctions for possession, or based on a constitutional ruling that criminalising drug possession is contrary to the country's constitution, or
- *de facto*, where drug possession is a criminal offence on the statute book but the police and the prosecution do not enforce the law.

Eastwood gave examples of where decriminalisation of drug possession had had a positive impact on drug use prevalence and problematic drug use. However, she identified implementation issues to be aware of:

- *Fine-tuning the mechanism*: Any decriminalisation policy needs careful monitoring and adjustment. For example, in South Australia, 'net widening' was found to occur: because the fine for drug possession had been set too high and a payment plan had not been put in place, many people ended up in prison for non-payment of the fine. The authorities adjusted the system, reducing the level of the fines and allowing for payment in instalments.
- *Politicians may be part of the problem*: Owing to a combination of hypocrisy, by being tough on drug users while also admitting to having used drugs in the past, and stupidity, through failing to listen to the debate or admit the need for review, politicians may delay the process of devising more effective drug policies.
- *Incrementalism*: Decriminalisation is not a panacea; it does not have any significant impact on the supply side or on drug-related crime. But Eastwood argued that it is part of an incremental reform process, as evidenced by subsequent reforms such as the establishment of cannabis social clubs in Spain, the legalisation of medicinal cannabis in the Czech Republic, and the setting up of fully regulated cannabis markets in the states of Washington and Colorado, and in Uruguay.

Release's survey of countries which have decriminalised drug use is the first of three reports in support of its campaign 'Drugs – It's Time for Better Laws', which was launched in the UK in June 2011. The second report, due in 2013, will look at the disproportionate impact of policing and prosecution of drug possession offences on black and Asian communities in the UK. The final report, due in 2014, will look at the economic costs associated with policing and prosecuting the possession of drugs in the UK.

(Brigid Pike)

1. For more information on Release, visit www.release.org.uk
2. Rosmarin A and Eastwood N (2012) *A quiet revolution: drug decriminalisation policies in practice across the globe*. London: Release. Available to download at <http://release.org.uk/publications/drug-decriminalisation-policies-in-practice-across-the-globe>

2013 UN world drug report

The UN's annual report on the world drug situation¹ shows that while the use of traditional drugs such as heroin and cocaine seems to be declining in some parts of the world, prescription drug abuse and new psychoactive substance abuse is growing.

New psychoactive substances have proliferated at an unprecedented rate, rising from 166 at the end of 2009 to 251 by mid-2012, an increase of more than 50%. This number exceeds the total number of substances (234) under international control.

While noting that different countries have adopted different responses to the spread of new psychoactive substances, for example early warning systems, emergency scheduling, generic scheduling (the option used in Ireland), or application of the medicines law, and that each has its pros and cons, the UN report argues that co-ordination at the global level is essential. Global co-ordination is the only means to ensure drug dealers do not exploit loopholes: 'What is needed is an understanding and sharing of methods and lessons learned in regional responses to the situation involving new psychoactive substances before exploring the setting up of a global response to the problem' (p.xiv).

The global picture for the use of traditional drugs such as heroin and cocaine shows some stability. In Europe, heroin use seems to be declining, while, the cocaine market seems to be expanding in South America and in the emerging economies in Asia. Use of opiates (heroin and opium), on the other hand, remains stable, although a high prevalence of opiate use has been reported from South-West and Central Asia, Eastern and South-Eastern Europe and North America.

In terms of production, Afghanistan retained its position as the lead producer and cultivator of opium globally (75% of global illicit opium production in 2012). But given a poor yield in 2012, owing to a plant disease affecting the opium poppy in Afghanistan, global opium production fell to 3% less than in 2011 and 40% less than in the peak year of 2007. The world's largest cocaine seizures, unadjusted for purity, continue to be reported from Colombia and the US. Cocaine use continues to fall in the US, the world's largest cocaine market. In contrast, significant increases in seizures have been noted in Asia, Oceania and Central and South America, and the Caribbean in 2011. Africa is emerging as a target for the trafficking as well as production of illicit substances.

The use of amphetamine-type stimulants (ATS), excluding ecstasy, remains widespread globally and appears to be increasing in most regions. The prevalence of ecstasy in 2011 was lower than in 2009. Methamphetamine continues to dominate the ATS business, accounting for 71% of global ATS seizures in 2011. Methamphetamine pills remain the predominant ATS in East and South-East Asia. Seizures of crystal methamphetamine in the region increased to 8.8 tons, the highest level during the past five years, indicating that the substance is an imminent threat. Mexico recorded its largest seizures of methamphetamine, more than doubling within a year from 13 tons to 31 tons, thus representing the largest reported seizures globally.

Cannabis remains the most widely used illicit substance. While cannabis use has clearly declined among young people in Europe over the past decade, there was a minor increase in the prevalence of cannabis users, as compared with previous estimates in 2009.

There continues to be a major shortfall in the delivery of treatment services for drug dependence: only an estimated one in six problem drug users had received treatment in the preceding year. However, the report shows that there have been some improvements. Those countries which implemented a comprehensive set of HIV interventions were able to achieve a reduction in high-risk behaviours and in the transmission of HIV and other blood-borne infections.

Compiled by the UN Office for Drugs and Crime (UNODC), the report is released each year on International Day against Drug Abuse and Illicit Trafficking, 26 June. In his preface to the report, UNODC executive director, Yury Fedotov, writes: 'We have to admit that, globally, the demand for drugs has not been substantially reduced and that some challenges exist in the implementation of the drug control system, in the violence generated by trafficking in illicit drugs, in the fast evolving nature of new psychoactive substances, and in those national legislative measures which may result in a violation of human rights.'

Fedotov argues, however, that the solution is not to amend the Conventions, but to implement them according to their underlying spirit. The problem will not be resolved if drugs are legalised: organised crime is highly adaptive, and will simply move to other businesses that are equally profitable and violent. The underlying spirit of the Conventions, according to UNODC's executive director, is health: 'Advocacy for a stronger health perspective and an interconnected re-balancing of drug control efforts must take place. As experience has shown, neither supply reduction nor demand reduction on their own are able to solve the problem. For this reason, a more balanced approach in dealing with the drug problem is a necessity. This includes more serious efforts on prevention and treatment, not only in terms of political statements, but also in terms of funds dedicated for these purposes.'

(Brigid Pike)

1. United Nations Office on Drugs and Crime (2013) *World drug report 2013*. Vienna: UNODC. www.drugsandalcohol.ie/20073/

Towards UNGASS 2016

UNGASS 2016 is a Special Session of the General Assembly of the United Nations, scheduled for early 2016, at which member states, including Ireland, will assess 'the achievements and challenges in countering the world drug problem, within the framework of the three international drug control conventions' (A/RES/67/193). The last UNGASS on drugs, in 1998, adopted a plan to make the world 'drug-free' by 2008. This column reports on policy initiatives, research, reviews, conferences and debates launched by member states and civil society organisations that are relevant to UNGASS 2016.¹

In May 2013 the **Canadian Drug Policy Coalition**, comprising 30 Canadian NGOs who came together in 2009 to advocate for improvements in Canada's approach to drug policy, published *Getting to tomorrow: a report on Canadian drug policy*. The authors call for 'a radical new direction – a course that will put the protection of public health and safety, social justice and equity at the forefront of Canada's strategy'. They identify four broad areas where improvements should be made: (1) modernise Canada's legislative, policy and regulatory frameworks that address psychoactive substances, replacing the national anti-drug strategy with one focused on health and human rights, the decriminalisation of all drugs for personal use and the creation of a regulatory system for adult cannabis use; (2) support and expand efforts to implement evidence-based approaches to eliminate stigma and discrimination, and social and health inequities that affect people who use drugs; (3) support the scaling-up of health and social services at the provincial level that engage people with drug problems and support their efforts to change, and support work to reduce the harms of substance use; and (4) improve the collection of data on substance use and its effects across jurisdictions. www.drugpolicy.ca/progress/getting-to-tomorrow/

In May 2013 the **Organisation of American States (OAS)**, comprising 35 states in North and South America, published a 400-page report on the drug problem in the Americas. The objective was to collect 'empirical evidence without prejudice' and to explore possible future scenarios while not 'defending any position, neither legalisation, nor regulation, nor war at any cost'. The report is in two main parts. *The drug problem in the Americas* examines the entire process of drugs in the region, the only part of the world in which all of its stages are present in a dominant way: cultivation, production, distribution and the final sale of controlled substances. *Scenarios for the drug problem in the Americas 2013–2025* explores the paths that the drug phenomenon could take in the hemisphere in the coming years. Three of the four scenarios describe different future alternatives: (1) *Together*, shifting from repressive approaches to ones that privilege citizen security and focusing on institution-building; (2) *Pathways*, experimenting with different approaches to regulating illicit drugs, and (3) *Resilience*, strengthening communities' capacity to respond to the problem. The fourth scenario, *Disruption*, outlines what could happen if states are incapable in the short run of reaching a shared vision that allows them to join forces to address the problem.

The report presents four broad conclusions:

1. options for dealing with the drug problem must take into account each country's particular situation;
2. countries with fewer resources and less institutional strength have more difficulty dealing with the impact of drug trafficking;
3. the drug phenomenon requires a public health approach; and
4. the approach to the problem must be multifaceted, flexible, and allow countries to collectively explore policy options on drugs, taking into consideration the needs, behaviours and particular traditions of each. www.cicad.oas.org/Main/Template.asp?File=/main/policy/default_eng.asp

In June 2013 the **Global Commission on Drug Policy** published *The negative impact of the war on drugs on public health: the hidden hepatitis C epidemic*. The report finds that of the 16 million people who inject drugs around the world, an estimated 10 million are living with hepatitis C. The report recommends immediate, major reforms of the global drug prohibition regime to halt the spread of hepatitis C infection and other drug war harms. www.globalcommissionondrugs.org/hepatitis/

In July 2013 the **Open Society Global Drug Policy Program**, launched in 2008 and funded by George Soros' Open Society Foundations, published *Coffee shops and compromise: separated illicit drug markets in the Netherlands*. A central element of modern Dutch drug policy has been the legal and practical separation of cannabis – judged to pose 'acceptable' risks to consumers and society – from hard drugs associated with unacceptable risk. The report describes the policy's positive impact on patterns of drug use and in reducing drug-related harms. It also examines the policy's negative effects, including public nuisance complaints and tensions arising from the supply of what is still an illegal substance. The report shows how, with its regulated approach to 'coffee shops', the Netherlands has been able to use regulatory mechanisms to address these problems. The authors conclude that, if there is one lesson to take away from the Dutch experience, it is that when taking steps toward regulating cannabis or other psychoactive substances, these should include the whole supply chain, from production to consumption. www.opensocietyfoundations.org/reports/coffee-shops-and-compromise-separated-illicit-drug-markets-netherlands

(Compiled by Brigid Pike)

1. While every effort will be made to describe in this column a broad range of initiatives, from a variety jurisdictions and civil society organisations, it will not be possible to provide comprehensive coverage.

EU action plan on drugs 2013–2016 adopted



On 6–7 June 2013 the European Council adopted the new EU action plan on drugs for 2013–2016.¹ Linked to the EU drugs strategy for 2013–2020,² this action plan is organised around five pillars:

- Drug demand reduction
- Supply reduction
- Co-ordination
- International co-operation
- Information, research, monitoring and evaluation

As the principle of ‘subsidiarity’ applies to illicit drug policy, i.e. member states have responsibility for drug policy within their borders, the action plan uses three policy instruments depending on whether there are opportunities for joint actions or cross-border co-operation.

1. Frameworks for co-ordinated and joint actions

Member states can either work together or co-ordinate their efforts under three pillars – Supply Reduction; Information, Research, Monitoring and Evaluation; and Co-ordination.

The Supply Reduction pillar includes a range of actions designed to enhance law enforcement and judicial co-operation between different member states, based on enhanced intelligence, threat assessments and information-sharing, and on use of mechanisms such as joint operations, joint investigation teams, memorandums of understanding and European arrest warrants. New emphases in the action plan include:

- a stronger focus on tackling money laundering, asset confiscation and drug trafficking;
- strengthening the law relating to new psychoactive substances and drug precursors;
- adopting and implementing EU regulations relating to the use of cutting agents;
- developing strategic responses to the emergence of drug-related crime via the internet, and training law enforcement personnel to combat the use of new communication technologies in illicit drug production and trafficking; and
- providing, where appropriate in accordance with member states’ legal frameworks, alternatives to coercive sanctions for drug using offenders.

The Information, Research, Monitoring and Evaluation pillar lists three objectives, which mirror the main functions of the European Centre for Drugs and Drug Addiction (EMCDDA), which funds a network of Reitox National Focal Points across all 28 member states:

- research and data collection, including funding research, and ensuring the accuracy, relevance and timeliness of monitoring, reporting and evaluation activities by all member states;

- maintaining networking and co-operation, and building capacity, with special emphases on improving capacity to detect, assess and respond to new psychoactive substances, strengthening efforts to share forensic science data across member states, and improving the ability to identify, assess and respond to behavioural changes in drug use and epidemic outbreaks; and
- dissemination of monitoring, research and evaluation results, ensuring all member states co-operate and support the EMCDDA’s work.

Responsibility for co-ordinating and monitoring the implementation of the EU drugs strategy and action plans lies with the holders of the EU presidency and the Horizontal Working Party on Drugs (HDG), a working party of the European Council. Implicit in this arrangement is a stronger role for member states that rotate the EU presidency and have diplomatic representation on the HDG.

The HDG takes on responsibility for promoting and supporting dialogue with both civil society and the scientific community (natural and social science and behavioural research) regarding the development and implementation of drug policy. The EU Civil Society Forum on Drugs will continue to represent civil society at EU level, but the European Alliance on Drugs, formed by the European Commission under the last EU drugs action plan, is not mentioned in the new action plan.³

2. Political framework for EU external co-operation in drugs field

The International Co-operation pillar proceeds on three diplomatic fronts, requiring policy positions to be based on the priorities and balanced approach set out in the EU drugs strategy:

- external relations, including initiatives to support alternative development, implement risk and harm reduction initiatives, tackle drug-related organised crime, including drug trafficking, maintain dialogues and declarations with external partners, ensuring the promotion and protection of human rights in the dialogues;
- UN and other international bodies, including improving the cohesiveness of the EU’s approach and its visibility in UN forums, and strengthening partnerships with UN and other international bodies; and
- acceding countries, candidate countries and potential members of the EU, supporting their adaptation to and alignment with the EU acquis in the drugs field.

3. Strategic approach that supports and complements national policies

Regarding demand reduction, the action plan calls on member states to measure, in association with the EMCDDA, the implementation of actions in three broad areas – prevention; treatment and rehabilitation; and co-ordinated, best-practice and quality approaches to drug demand reduction. New initiatives include tackling the misuse of

EU action plan 2013–2016 (continued)

prescribed and 'over-the-counter' opioids, and providing recovery and social re/integration services alongside treatment and rehabilitation.

Measuring performance

The action plan includes a list of 15 overarching indicators that will be used to assess the overall effectiveness of the action plan. Fourteen of these indicators are based on data already collected by the EMCDDA. The use of additional indicators will depend on member states providing extra data on topics such as the level and patterns of prescribing of psychoactive medicines, or the level of involvement of civil society in drug policy development and implementation, with particular regard to the involvement of drug users, clients of drug-related services and young people. The action plan emphasises the need to increase the availability and

use of evidence-based and scientifically sound indicators. Work is to continue on developing a roadmap to standardise, improve and streamline data collection of key drug supply indicators and getting agreement from all member states on these indicators.

(Brigid Pike)

1. Council of the European Union (2013) *Draft EU action plan on drugs (2013–2016)*. 9963/13. Brussels: Council of the European Union. www.drugsandalcohol.ie/20004
2. See Pike B (2013) New EU drugs strategy reflects 'new thinking'. *Drugnet Ireland*, (45): 7. www.drugsandalcohol.ie/19683
3. See Pike B (2009) EU sets priorities for drug policy 2009–2012. *Drugnet Ireland*, (29): 25–26. www.drugsandalcohol.ie/12180

Status report on alcohol and health in Europe

In 2012, the WHO Regional Office for Europe collected information on alcohol consumption and related harm, and countries' policy responses to contribute to the Global Information System for Alcohol and Health. The resultant report presents a selection of the results for 35 countries – EU member states and candidate countries, and Norway and Switzerland.¹

Alcohol consumption and related harm

The most recent data collected from the 35 countries show that adults aged 15 years and over consumed 9.4 litres of alcohol per capita in 2010. The corresponding figure for EU countries only was 10.2 litres. There was a marked decrease in recorded adult per capita alcohol consumption in the EU as a whole between 1990 and 2010. This was mainly due to a reduction in consumption in southern European countries (Cyprus, Greece, Italy, Malta, Portugal, and Spain) that started before 1990.

Alcohol has been established as a major risk factor for premature mortality in the EU, and the overall level of alcohol-attributable mortality in the EU is high, as measured by mortality due to the three most important alcohol-attributable causes of death, namely, cancers, liver cirrhosis and injuries. Alcohol-attributable mortality was highest in the central-eastern and eastern country group (Bulgaria, Croatia, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia and Slovenia), where alcohol consumption is on the increase. According to the report: 'A simple regression analysis indicates that the correlation between adult per capita consumption of alcohol and alcohol-attributable mortality is strong ($R^2 = 0.70$), and that the number of alcohol-attributable deaths increases exponentially as adult per capita consumption increases' (p.7).

Alcohol consumption can result in many types of harm to people other than the drinker, which are difficult to quantify. This report estimates only the alcohol-attributable harm to others due to motor vehicle accidents and assaults. In the EU, Croatia and Switzerland in 2010, 1.04 deaths per 100,000 people (0.56 deaths per 100,000 women and 1.55 deaths per 100,000 men) were caused by alcohol-attributable motor vehicle accidents and assaults. This represents 9.9% of all alcohol-attributable injury deaths (30.2% of all alcohol-attributable injuries for women and 7.9% of all alcohol-attributable injuries for men). The burden of alcohol-attributable harm to others was greatest in the central-eastern and eastern country group, with 2.23 deaths per 100,000 people (1.20 deaths per 100,000 women and 3.36 deaths per 100,000 men).

European survey on alcohol and health 2012

Part 2 of the report presents the results of the EC/WHO survey on alcohol and health, carried out in 2012. The survey was sent to the national WHO focal points for alcohol policy in each country, to be completed in consultation with various national experts. Respondents were asked to rate whether action in various policy areas had been strengthened, weakened or remained



Alcohol and health in Europe (continued)

unchanged over the past five years.

The areas in which the most countries (excluding the five EU candidate countries) reported positive developments were public awareness-raising (23 countries), drink-driving policies and countermeasures (22 countries), and monitoring and alcohol research (21 countries). Two thirds of the countries (20) reported strengthened action in controlling the availability of alcohol. However, two of the most effective policy measures have seen fewer positive policy developments in recent years, with the majority of countries reporting that policies to control the affordability of alcohol (17 countries) and policies to regulate the marketing of alcoholic beverages (19 countries) had either been weakened or remained unchanged. At the end of 2011, 23 countries had a written national policy on alcohol; six of the remaining seven were in the process of developing such a policy.

According to the report:

All 30 countries reported that excise duty is levied on beer and spirits. However, just over one third of the countries do not have an excise duty on wine. Only four countries reported that the level of excise duty is regularly adjusted for inflation. ... A few countries reported using price measures other than taxation. At the end of 2011, Germany and Sweden prohibited below-cost selling (selling for a price less than the production cost), and Finland and Sweden prohibited volume discounts (such as two-for-one offers) (p.20).

Major steps or milestones in the development of policy

Alcohol policy timelines for each country were also reported. These timelines are a summary of the major steps taken or milestones reached in each country in the development of policy and action to reduce alcohol-related harm during the period 2006–2012. The milestones reported by Ireland include:

- the establishment of the Government Alcohol Advisory Group in 2007 to examine the law governing the sale and consumption of alcohol;
- The Intoxicating Liquor Act 2008;
- the establishment of a code of practice on the display and sale of alcohol in mixed trading premises in 2008;
- the enactment of the Road Traffic Acts 2010 and 2011, which reduced the maximum legal blood alcohol concentration (BAC) when driving a vehicle, and made provision for the mandatory testing of drivers at collision sites and in hospital following a road traffic collision; and
- the publication of *Steering group report on a national substance misuse strategy in 2012*, which is a roadmap for the future direction of policy to deal with the use and misuse of alcohol.

Conclusion

The report concludes:

In principle, all alcohol-attributable deaths are avoidable, and there are clear indications that policy measures can be implemented which could decrease alcohol-attributable mortality markedly in a relatively short period of time. The most important of these measures would be increased taxation, decreased availability, bans on advertising and marketing, and an increase in treatment rates for people with alcohol problems. (p.11)

(Deirdre Mongan)

1. World Health Organization (2013) *Status report on alcohol and health in 35 European countries 2013*. Copenhagen: WHO Regional Office for Europe. www.drugsandalcohol.ie/20017

Physicians urge action on alcohol-related harm

The Royal College of Physicians (RCPI) established a policy group on alcohol in 2012. Its members are all experienced medical professionals working in a variety of disciplines and its remit is to highlight the rising levels of alcohol-related health harm in Ireland, to propose evidence-based solutions to reducing this harm, and to influence decision-makers to take positive action to address the damage caused by alcohol use. The group published its first policy statement in April 2013.¹

The policy statement outlines the evidence regarding alcohol consumption and alcohol-related harm in Ireland:

- Ireland's adult per capita consumption of alcohol was 11.9 litres in 2010, the sixth highest level of consumption in the European Union that year.
- In 2008, there were 88 deaths every month which were directly attributable to alcohol.
- A 2006 study showed that more than half of all people who died from suicide had alcohol in their blood.
- The rate of discharges for alcoholic liver disease increased by 247% for 15–34-year-olds, and by 224% for 35–49-year-olds between 1995 and 2007.

- Approximately 5% of newly diagnosed cancers and cancer deaths are attributable to alcohol, i.e. around 900 cases and 500 deaths each year.
- Alcohol-related disorders accounted for 1 in 10 first admissions to Irish psychiatric hospitals in 2011.

The statement makes a number of recommendations that should be implemented immediately to reduce alcohol-related harm. Many of these recommendations have already been outlined in the Department of Health 2012 *Steering group report on a national substance misuse strategy*.² They include:

- introducing minimum pricing;
- phasing out alcohol sponsorship of sports events and organisations;
- reducing the number of alcohol outlets;
- strictly controlling low cost sales promotions and discounts;
- disseminating guidelines on low risk levels of alcohol consumption; and

Physicians on alcohol-related harm (continued)

- labelling alcohol products sold in Ireland to show units of alcohol, grams of alcohol per container, calorific content and health warnings.

In addition, the policy group proposes a number of actions within the health system aimed at reducing damage to health caused by alcohol misuse. It proposes that alcohol screening and brief interventions be embedded in clinical practice and recommends that an integrated model of care be developed for treatment of alcohol-related health problems. It also recommends that the government allocate specific funding for research into alcohol-related harms, especially alcoholic liver disease.

In addition to producing further evidence-based policy statements, the group

plans on raising awareness of alcohol health harm through media campaigns and public meetings, and

considering how outcomes of the evidence-base can be translated into postgraduate medical training and education. The policy statements and awareness of alcohol health harm will add to the national debate on the issue and, importantly, will recommend tangible actions to reduce damage to health caused by alcohol misuse. (p.5)

(Deirdre Mongan)

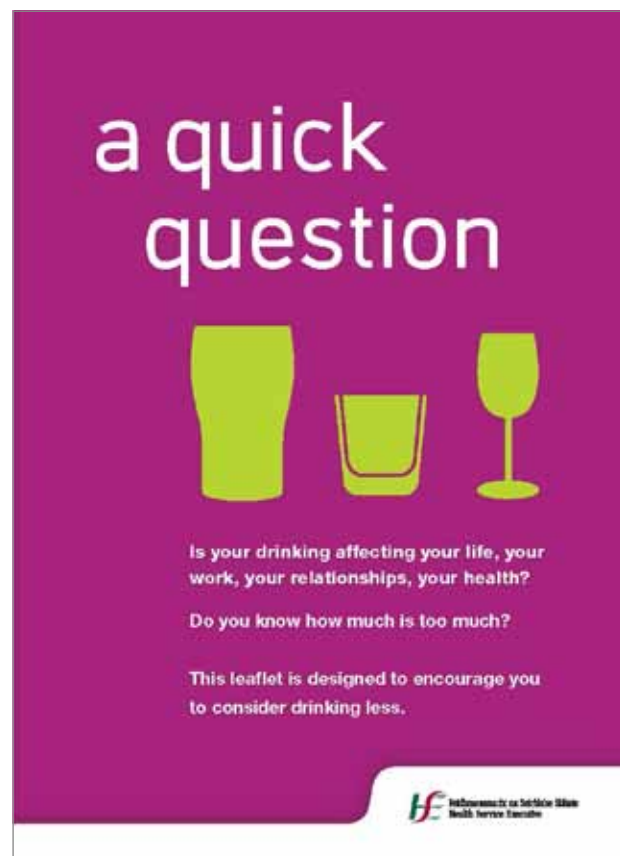
1. Royal College of Physicians of Ireland Policy Group on Alcohol (2013) *Reducing alcohol health harm*. Dublin: RCPI. www.drugsandalcohol.ie/19732/
2. Department of Health (2012) *Steering group report on a national substance misuse strategy*. Dublin: Department of Health. <http://www.drugsandalcohol.ie/16908/>

'A quick question' – alcohol screening and intervention

The Health Service Executive (HSE) did a feasibility test for alcohol screening and brief interventions in four hospital emergency departments during December 2009 and February 2010. Staff in the emergency departments asked attendees 'a quick question' about their alcohol use. Discussing the feasibility test, project manager Ruth Armstrong, Health Promotion HSE, explained 'the initiative showed that there was good co-operation from the public, with 94% of people agreeing to be screened. This shows the value of the screening but also helps to reassure staff that people were happy to take part.' This view is further supported by a survey¹ which found that there is near complete support (95% or over) for healthcare professionals asking about alcohol consumption where there is a link to the condition or treatment. While there is less support in the context of routine history taking, support remains strong at 89%.

The HSE leaflet, *A quick question*, was developed as a resource for staff undertaking screening and carrying out brief interventions with service users during the feasibility test. The leaflet was based on the design and content of the UK Department of Health (2006) booklet, *How much is too much*.² The content was designed to encourage people to consider drinking less. It contains information on standard drinks, risks from drinking alcohol, benefits of cutting down, planning your evening, partying safely and where to get further information and help.

Following the results of the feasibility test the HSE developed a new national programme for the education and training of nurses and midwives in screening and brief intervention for problem alcohol use. The framework to support this training programme, which was introduced during 2012, was developed by the HSE Alcohol Screening and Brief Intervention project, Nursing and Midwifery Services (ONMSD) and a range of service providers. During 2013, the training programme is being rolled out to staff working in Tier 1 services as part of the National Addiction Training Programme within HSE Social Inclusion services.



Professor Joe Barry, project lead, outlined the purpose of the programme: 'We are all aware of the harm caused by alcohol use in Ireland, and the cost to individuals, families and society – including the health service. Our health services are an ideal setting in which to screen people for alcohol use, and offer help to people with problem alcohol use. In order for this to happen, staff training is essential, and this framework provides the template for this training.'

Alcohol screening (continued)

A further screening and brief intervention resource has recently been developed in partnership with drugs.ie. An online alcohol self-assessment tool with video-based brief interventions will be rolled out on the drugs.ie website and FaceBook page. Those whose alcohol use is likely to be harming their health or increasing their risk of future harm are the main target group for this initiative.

To order copies of *A quick question*, please go to the publications section at www.healthpromotion.ie. For more information on the Alcohol Screening and Brief Intervention project, please contact Ruth Armstrong at ruth.armstrong@hse.ie or go to www.hse.ie/eng/services/Publications/topics/alcohol/alcoholscreening.html

(Ruth Armstrong, HSE)

1. Ipsos MRBI (2012) *Alcohol: public knowledge, attitudes and behaviour*. Dublin: Health Research Board. www.drugsandalcohol.ie/18022
2. ESRC Centre for Organisation and Innovation (2006) *How much is too much? Drinking and you*. London: Department of Health. Accessed 4 July 2013 at www.sips.iop.kcl.ac.uk/download.php?id=135

Drugs, alcohol and children's lives – strategy to improve our understanding

The first implementation report on the National Strategy for Research and Data on Children's Lives 2011–2016¹ presents the progress made in the two years since the strategy was published in November 2011.²

The aim of the national research and data strategy is to set out a plan to guide and support the development of research and data around children's lives over the lifetime of the strategy to ensure that children and young people benefit from improved understanding of their lives. The strategy works towards the development of a comprehensive and co-ordinated approach to the collection, compilation and dissemination of research and data on children's lives and facilitates the use of good quality, easily accessible, internationally comparable information.

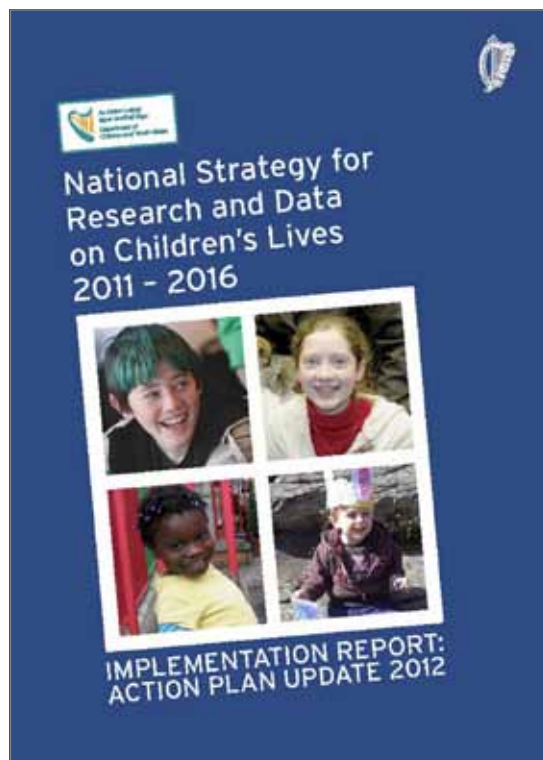
Strategic objectives

The strategy has five objectives:

- A. to generate a comprehensive and coherent understanding of children's development, preferences, needs and appropriate supports and services;
- B. to develop research capacity in the area of children's research and data;
- C. to develop, support and promote good infrastructure in the area of children's research and data;
- D. to improve monitoring and evaluation of children's services at local, national and international level; and
- E. to support a continuum of research and data use within policy and practice settings.

Seven actions relating to enhancing research and data on drugs and alcohol are listed under strategic objectives A and C. It is intended that completion of these actions will contribute in turn to completion of Action 37 in the National Drugs Strategy 2009–2016: 'Develop and implement a mechanism for early identification, and onward referral where appropriate, of substance misuse among under-18 service users in the wider statutory, community and voluntary sectors'.

A10: The Department of Health is tasked with two actions to improve, and increase the use of, research and data on the topic of alcohol and drugs in relation to children's



lives. With the expiry of the mandate of the National Advisory Committee on Drugs (NACD) at the end of 2011, however, no decisions on new research in the drugs and alcohol areas have been made.

A16: The Health Research Board is responsible for four actions – two involve mining ESPAD (European School Survey Project on Alcohol and other Drugs) and other data sources to produce electronic reports on the interaction between drug use and youth offending, and on drug misuse among children and young people, and the other two call for the publication of an annual digest of national research on the topic of drugs in relation to children's lives and an annual report summarising existing survey data on drug misuse by children and young people.

Drugs, alcohol and children's lives (continued)

CS: The Department of Health is tasked through the NACD with completing a feasibility study to identify data sources and research methods to provide a baseline indicator of substance misuse among youth at risk. Once established, this baseline indicator will continue to be monitored and reported on every four years. The hold up in re-mandating the NACD has seen a delay in starting this action.

Outcome areas

When developing the national research and data strategy, a forensic and systematic analysis was undertaken in order to identify research and data gaps and existing data sources and to agree priorities. Gaps and priorities were presented in the strategy according to five outcome areas, which were based on the national service outcomes defined in *The agenda for children's services*.³ The outcomes are that children will be:

1. healthy, both physically and mentally;
2. supported in active learning;
3. safe from accidental and intentional harm, and secure in the immediate and wider physical environment;
4. economically secure;
5. part of positive networks of family, friends, neighbours and community, and included and participating in society.

With regard to outcome 3, risk behaviours such as smoking, alcohol and drug use by children, parents and others in their broader environment were to be taken into account, and crimes committed by, and against, young people were also to be included. Preventive, protective and remedial services were also to be considered, with a particular focus on describing, documenting, identifying and evaluating interventions.

Knowledge transfer

Four issues that cut across research and data needs in all outcome areas of children's lives were also identified in the strategy:

- (a) development of a national strategic approach to information;
- (b) improvement of administrative data systems;
- (c) building capacity across all areas of research and data development, particularly analytic capability; and
- (d) supporting evidence-informed policy and practice.

With regard to (d), improved dissemination techniques and practices, particularly the need for material to be available in a timely fashion and for the employment of multiple dissemination techniques, were regarded as vital. The importance of knowledge transfer was recognised, particularly given the complexity of the policy-making process. The strategy highlighted the need to link data findings more closely to policy and service delivery with, for example, the development of short policy briefings tailored to the needs of particular communities. Some national initiatives already in existence which could support improved knowledge transfer were listed, including the Health Research Board's National Documentation Centre on Drug Use (www.drugsandalcohol.ie).

(Brigid Pike)

1. Department of Children and Youth Affairs (2013) *National strategy for research and data on children's lives 2011–2016. Implementation report: action plan update 2012*. Dublin: Department of Children and Youth Affairs. www.drugsandalcohol.ie/20177
2. Department of Children and Youth Affairs (2011) *National strategy for research and data on children's lives 2011–2016*. Dublin: Department of Children and Youth Affairs. www.drugsandalcohol.ie/16432
3. Office of the Minister for Children (2007) *The agenda for children's services: a policy handbook*. Dublin: Department of Health and Children. Downloaded on 18 July 2013 from [www.dcyh.gov.ie/viewdoc.aspx?fn=/documents/Publications/CS_handbook\[ENGLISH\]lowres.pdf](http://www.dcyh.gov.ie/viewdoc.aspx?fn=/documents/Publications/CS_handbook[ENGLISH]lowres.pdf)

Suboxone feasibility study evaluated

In June 2013 the Department of Health released the results of an evaluation of the Suboxone feasibility study which started in June 2009.¹ The evaluation was carried out between October 2010 and February 2011. The objectives of the evaluation were to:

- evaluate how patients were selected for participation and how they progressed through the study;
- examine how the prescribing and dispensing of Suboxone operated in an Irish context;
- consider the practical operation of the feasibility study;
- identify the core elements of the regulatory framework needed for the safe use of Suboxone in Ireland.

A variety of methods was used to evaluate the feasibility study: analysis of quantitative and clinical records, semi-structured interviews, and surveys. Not all patients who had started on Suboxone could be contacted for consent to be included in the evaluation and not all patient records were

available to be audited. Other stakeholder involvement consisted of: eight semi-structured interviews with prescribers; 13 semi-structured telephone interviews with pharmacists/dispensers; 36 responses to semi-structured survey of patients (completed either on-line, on paper or over the telephone); two face-to-face interviews with patients and two written submissions from patients. The clinical notes and dispensing records were reviewed for 41 patients. There were five key informant interviews.

A total of 139 patients registered as having received Suboxone between 2006 and 2011 were eligible to be included in the evaluation. Also included were 11 prescribers based in the Drug Treatment Centre Board (DTCB), seven prescribing GPs based in other clinics or practices, and 50 dispensers, the majority (78%) of which were community pharmacies. Table 1 outlines the characteristics of those included in the evaluation and the reason for exit.

Suboxone study evaluated (*continued*)

Table 1 Treatment statistics from Suboxone database

Total number of eligible patients	N = 139
Males	91 (66%)
Females	48 (34%)
Patients previously treated with methadone	76 (55%)
Total number of treatment episodes	N = 149*
<i>Age in years of patients starting each treatment episode</i>	
Under 18	6 (4%)
18 to 25	31 (21%)
26 to 35	60 (40%)
36 to 45	39 (26%)
46 and over	13 (9%)
Type of treatment at start of episode	
Detoxification	27 (18%)
Opiate maintenance	122 (82%)
Patient outcomes	N = 139
Still in Suboxone treatment on 31 Jan 2011	63 (45%)
Exits from treatment (or from treatment episode)	76 (55%)
Reason for exit	N = 86
No contact	29 (34%)
Transfer to other opioid substitute	23 (27%)
Treatment successfully completed	19 (22%)
Treatment failure	7 (8%)
Gone abroad	5 (6%)
Deceased†	1 (1%)
Other	2 (2%)
* 10 patients were in Suboxone treatment on two separate occasions, which accounts for the 149 treatment episodes.	
† The death was unrelated to Suboxone treatment.	
Source: Adapted from <i>Evaluation of Suboxone feasibility study in Ireland</i> , pp. 9, 11 and 13.	

Process and limitations of the study

The author noted several issues that may influence the results and generalisability of the evaluation. She was unable to contact a number of patients who had received Suboxone but who were no longer in contact with the treatment services. Not all who consented to be included in the evaluation could be contacted subsequently. Also, the evaluation only included the opinions of those who had been involved in the original feasibility study, who therefore might already have been positively disposed to the use of Suboxone.

Rationale for commencing Suboxone

The main reasons for prescribing Suboxone, as recorded in the clinical notes or dispensing record for 41 patients, were: patient had low level of heroin dependence, either having never injected, had rarely injected or had a short history of heroin use (16, 39%), and patient requested it, or did not want methadone (10, 24%) (Table 2). The survey of patients showed that the majority (79%) felt that Suboxone was the best option for them after discussions with their doctor. Of 22 patients previously prescribed methadone, 45% had experienced side-effects. Of 11 who had never been prescribed methadone, 55% wanted detoxification (i.e. to be substance free) rather than to stay on opiate substitution treatment.

Suboxone study evaluated (*continued*)

Table 2 Reasons for Suboxone prescription

Records reviewed	N = 41
<i>Main drug of dependence</i>	
Heroin (injected)	24 (58%)
Heroin (smoked)	10 (24%)
Codeine	4 (10%)
<i>Selection of patients/reason for Suboxone prescription</i>	
Low level of heroin dependence	16
Patient requested it, or did not want methadone	10
Treatment for detoxification	6
Previous failed methadone or particular difficulties with methadone	5
Stable	5
Medical need	4
Codeine dependent/oxycodone dependent	5
Previous buprenorphine treatment	3
Unclear	2

Patient experience of Suboxone

The majority of the 36 patients who participated in the evaluation were very positive about their experience of Suboxone, and many were still on the treatment. They reported benefits such as 'feeling like themselves again, reduced cravings' and returning to a more normal life. On the downside, several commented on the difficulties of having to be in withdrawal in the early stages of Suboxone treatment, which may be a barrier for some individuals.

Prescribing and dispensing

The evaluation found that there were three different protocols on the use of Suboxone in circulation at the time of the feasibility study. There was an informal system of training and support for doctors who participated in the study. The dosage and initiation regimes used ranged from 2mg to 26mg daily. It was noted that Suboxone is licensed only for provision of doses up to 24mg in any one day, and that the possibility of less-than-daily dosing was mentioned in only one of the protocols, underlining the need for clinicians to share their experience in this area.

There were issues highlighted with the prescription form for Suboxone, in particular when the prescription did not comply with the requirements of the Misuse of Drugs Act. Problems reported with the availability of 2mg Suboxone tablets caused some difficulties for pharmacists. Patients were supplied with a variety of information documents and/or verbal advice on starting Suboxone. However some of the patients reported that they had forgotten what they had been told when first prescribed Suboxone, highlighting the need for standardised, accessible written information.

Participants were asked about the possibility of diversion of Suboxone. The consensus was that there was little or no diversion due to the tight controls and stability of the patients. In the patient survey, 76% reported that Suboxone was not available on the street.

Costs

This evaluation discusses the 2007 report done by the National Centre for Pharmacoeconomics (NCPe) for the expert group.² That report concluded that on current evidence Suboxone could not be considered cost effective for patients attending HSE clinics unless opiate abstinence rates were at least 10% higher with Suboxone than with

methadone. The evaluation noted that the low cost of methadone makes comparing costs with any other treatment difficult. It was felt that societal costs had not been factored into the NCPe report and that, although more expensive than methadone, providing Suboxone to certain patients for whom there is a clear rationale would have economic and societal benefits.

Regulating provision

There was no clear consensus among prescribers or key informants as to what was the most appropriate mechanism to regulate provision, as each had both positive and negative aspects. The issues discussed were:

- having a cap on the number of patients who can be prescribed Suboxone;
- having a fixed budget cap (rather than a cap on patients);
- restricting prescribing to certain groups of prescribers and/or patients;
- negotiation with the relevant pharmaceutical company on price.

Conclusions and recommendations

The evaluation concludes that 'Suboxone has been used in this feasibility study with a wide range of patient groups, for whom it has the potential to be beneficial and it appears to offer a number of advantages over methadone' (p.44). In considering future safe provision of Suboxone in Ireland, it makes a number of recommendations (pp.44–47), which are summarised below.

1. The Suboxone Expert Group discuss and agree interim criteria for who should be eligible for Suboxone treatment.
2. If Suboxone prescribing is restricted to certain groups/subjected to certain criteria in future, audit and reporting processes should be established to add weight to the criteria and enable any prescribing patterns that are unusual or fall outside the criteria to be identified and explored.
3. National guidelines on the use of Suboxone across all prescribing and dispensing settings should be developed.

Suboxone study evaluated (*continued*)

4. Standard patient information resources should be used across all settings.
5. Prescriptions for Suboxone should be designed for clarity and avoidance of ambiguity.
6. The system for remuneration of Suboxone in future should be incorporated into remuneration systems for opioid treatment services and should be clearly communicated to prescribers and dispensers (including any future prescribers and dispensers).
7. Clarification of the ethical and legal position of pharmacists and clinics in relation to the various options for coping with stock shortages should be provided. Professional guidance should be prepared in relation to the appropriate management of such situations.
8. Arrangements should be made for the appropriate management of Suboxone stock which may be left in pharmacies where they no longer have any patients on the drug.
9. Suboxone should be made available through more than one wholesaler to reduce the likelihood of stock shortages.
10. Suboxone initiation and prescribing should be restricted to those with suitable expertise and training.
11. Suboxone dispensing should be restricted to those with suitable expertise and training.
12. There is a need for a mechanism for prescribers to share and discuss their experiences with Suboxone (and in the management of opioid dependence in general, including methadone).
13. Engagement should take place with the pharmaceutical company marketing Suboxone in order to consider price, budget projections and shared-risk arrangements for any future use of Suboxone.
14. Any future consideration of the cost-effectiveness of Suboxone should take into account the full range of potential benefits from successful treatment of opioid dependence, including reduced social costs.

(Suzi Lyons)

1. Fitzgerald N (2011) *Evaluation of Suboxone feasibility study in Ireland*. Dublin: Department of Health. www.drugsandalcohol.ie/19976
2. National Centre for Pharmacoeconomics (2007) *Economic evaluation of the use of Suboxone for opiate addiction*. Summary. Dublin: National Centre for Pharmacoeconomics. www.ncpe.ie/wp-content/uploads/2007/12/Suboxone-summary.pdf

Proposed regulatory framework for buprenorphine/naloxone products in Ireland

The drug Suboxone, a combination of buprenorphine and naloxone, was licensed for use in 2006 in Ireland as an alternative to methadone for opiate dependency. In 2007 the Department of Health set up an expert group to examine the regulatory framework for products containing buprenorphine/naloxone and buprenorphine-only.¹ The expert group considered a number of relevant documents, including the evaluation of a feasibility study on the use of Suboxone in Ireland.² (That evaluation is reviewed on p.19 of this issue.) The report of the expert group is now available.³ The terms of reference of the group are outlined below, with a summary of its deliberations and associated recommendations.

1. *In the context of the product authorisation for Suboxone issued by the European Medicines Agency, to consider and make a recommendation as to whether the general regulation of relevant professions provides a sufficient regulatory framework for the prescription and dispensing of buprenorphine/naloxone, or buprenorphine-only products in Ireland.*

The group concludes that the regulations and guidelines for the prescribing and dispensing of methadone can also apply to buprenorphine/naloxone, or buprenorphine-only products.

2. *To consider and make recommendations if appropriate as to which if any elements of the methadone protocol should apply to Suboxone, and if so how they could apply in practical terms.*

The group concludes that the Methadone Protocol Scheme can also apply to the prescribing and dispensing of

buprenorphine/naloxone or buprenorphine-only products, and that the details of patients receiving these products should be recorded on the Central Treatment List. Other general recommendations include having consistent and uniform guidelines for prescribing and dispensing these products, that the current methadone prescription form should be adapted for them, the need for co-ordinated multi-disciplinary training, and a system of clinical governance and audit for GPs and pharmacies.

3. *To consider and make recommendations if appropriate as to whether and if so how Suboxone should be made available to particular client groups and/or settings in an Irish context, taking into account the work done by the NACD and taking into account the cost of this treatment.*

The group concludes that methadone is the drug of first choice for treating opiate dependency, but that buprenorphine/naloxone may be appropriate for some patient cohorts in certain circumstances, as follows:

- patients already receiving treatment with buprenorphine/naloxone;
- patients with a specific medical condition where methadone is contraindicated, for example prolonged QT interval;
- patients who have never been prescribed methadone before, especially young patients, where detoxification is a primary goal of treatment;
- patients whose main problem drug is codeine or another pharmaceutical opiate;

Regulatory framework (continued)

- patients who the prescriber believes to be stable for at least six months, particularly in regard to employment or education, and committed to compliance with the treatment.

After individual patient risk assessment, less-than-daily dosing can be considered, with frequency down to every second day or even to three times per week after a satisfactory level of stabilisation. The total amount of Suboxone given on any one day must not exceed the maximum of 24mg authorised by the European Medicines Agency.

The group states that the economic factors involved were outside the scope of their deliberations but were relevant to the establishment of a buprenorphine/naloxone treatment protocol and should be considered. These included:

- findings of the economic evaluation done by the National Centre of Pharmacoeconomics in 2007⁴ which found that Suboxone and buprenorphine-only could not be considered cost effective when compared to methadone in clinics or in the community;
- generic pricing discussions between the HSE and the manufacturer;
- issues around HSE clinics which have their own budgets and consistency of treatment; and
- contractual implications in relation to prescribing and dispensing for both GPs and pharmacists.

The group advises that the recommendations be reviewed within two years of the date on which they were given to the Minister, to allow for new research and evidence to be taken into account.

4. **To consider and make recommendations if appropriate as to whether and if so in what way buprenorphine-only products should be available in Ireland.**

The group is not aware of any buprenorphine-only products being marketed in Ireland to treat opiate dependence. They acknowledge that, while not authorised in Ireland, buprenorphine-only products may be prescribed for pregnant women in certain circumstances, and with appropriate advice and warning. They advise that if a buprenorphine-only product were to be prescribed and dispensed in Ireland, it should be done with extreme caution due to the high risk of diversion and potential for use by injection.

5. **To consider any legal advices received in relation to the above matters.**

After taking legal advice, the group decided that if buprenorphine/naloxone or buprenorphine-only products were to be used in Ireland then the appropriate changes will have to be made to the misuse of drugs legislation and the regulations for the prescription and supply of methadone.

(Suzi Lyons)

1. Long J (2007) Suboxone licensed in Europe. *Drugnet Ireland*, (22): 25. www.drugsandalcohol.ie/11396
2. Fitzgerald N (2011) *Evaluation of Suboxone feasibility study in Ireland*. Dublin: Department of Health. www.drugsandalcohol.ie/19976
3. Expert Group on the Regulatory Framework (2011) *Recommendations of the Expert Group on the Regulatory Framework for products containing buprenorphine / naloxone and buprenorphine-only for the treatment of opioid dependence*. Dublin: Department of Health. www.drugsandalcohol.ie/19977
4. National Centre for Pharmacoeconomics (2007) *Economic evaluation of the use of Suboxone for opiate addiction*. Dublin: National Centre for Pharmacoeconomics. www.ncpe.ie/wp-content/uploads/2007/12/Suboxone-summary.pdf

Clinical practice guidelines for prescribing methadone in pregnancy

New clinical practice guidelines on safe and effective prescribing of methadone for pregnant women in maternity hospitals were jointly published in April 2013 by the Institute of Obstetricians and Gynaecologists and the Health Service Executive. Based on an earlier document used by the three Dublin maternity hospitals, these new guidelines were developed after a wide-ranging review of the literature and consultation with key stakeholders.

The document recommends that all pregnant women with problem opiate use should attend a specialist or high-risk antenatal clinic. If this is not possible, the woman should attend the same clinic throughout her pregnancy to ensure continuity of care.

The guidelines work through various common clinical scenarios and issues around admission and discharge. They are designed to guide clinical judgment, not replace it.

Clinical Scenario 1: Pregnant women admitted and known to be on prescribed methadone from medical record or verbal history.

- Their methadone provider should be contacted to confirm details. The hospital medical team should ensure that methadone is prescribed in a timely manner.

Clinical Scenario 2: Pregnant women admitted with a take-away methadone supply.

- Women should be advised not to bring supplies of take-away methadone into hospital. If they do, the methadone must be sent to the pharmacy to be destroyed.

Clinical Scenario 3: Pregnant women admitted to hospital self-reporting heroin use but not registered with the addiction services or a prescribing GP.

- This group of women need to be assessed and treated in a timely manner, given that opiate withdrawal carries the risk of pre-term delivery and foetal death. It is advisable to seek guidance from the local addiction services and also to confirm that the woman is opiate dependent. The management of initiation of any methadone treatment should be closely monitored.

Guidelines for methadone in pregnancy (*continued*)

Clinical Scenario 4: Pregnant women admitted looking for a prescribed dose of methadone out of hours and known to be on prescribed methadone from medical record or verbal history.

- As methadone cannot be administered on an out-patient basis, the woman must be admitted, then up to a maximum of half her current dose prescribed.

Intoxicated pregnant women

- Because of the risk of overdose, methadone must not be dispensed to a woman who may be intoxicated until they have been medically assessed.

Vomiting in pregnant women on methadone-maintenance treatment

- Vomiting may not be related to the methadone, so other possible causes should be investigated, e.g. hyperemesis gravidarum. Depending on the time lines and amount vomited, a proportion of, or all of the dose may be re-administering.

Discharge of methadone-maintained women

- All details of the woman's methadone prescription should be sent to the prescriber in the community (either clinic or GP). Women should not be discharged with supplies of methadone from hospital stock or a prescription for methadone or benzodiazepines.

Peripartum pain management

- Women on methadone treatment should be offered, if required, the same pain relief options as other women for labour or post-partum pain, as maintenance doses of methadone do not provide adequate pain relief. They should be reassured that there is no evidence that the administration of opiates for pain relief leads to relapse, however they may require higher doses to provide effective relief.

Breastfeeding

- Women who are stable on methadone and have no contra-indications should be encouraged to breastfeed if they wish. However if the woman is on other medication, e.g. benzodiazepines, advice should be sought.

Methadone dosing in pregnancy

- This can be a difficult area to manage, particularly because of the complexities of pregnancy-associated pharmacokinetic changes which have been shown to reduce the concentration of methadone in the blood. Some women may wish to reduce their dose in order to reduce the risk of neonatal abstinence syndrome in their infant; however, there is no evidence to support this theory. Each woman's dose, her tolerance and its effectiveness should be monitored and titrated closely during the pregnancy. Because of the risk of relapse and the subsequent risk to the foetus, detoxification from methadone is not recommended during pregnancy.

Key recommendations

(reproduced from p.3 of *Clinical practice guideline*)

1. Methadone maintenance treatment is the treatment of choice for opioid-dependent pregnant women. In adequate doses, methadone provides stability for the woman during pregnancy, avoiding repeated cycles of intoxication and withdrawal that may adversely affect the foetus.
2. Withdrawal from opioids can cause foetal death and preterm delivery. It is important that women who report illicit opiate use are assessed and treated in a timely manner.
3. Clear communication between maternity hospitals and local addiction services is required, particularly in relation to methadone doses and admission/discharge of methadone-maintained women.
4. Initiation of methadone may be required in a maternity hospital to avoid obstetric complications of opioid withdrawal. Careful initiation is required, as the highest risk of overdose mortality is in the first two weeks on methadone treatment.
5. A validated scoring tool should be used to assess signs of opioid withdrawal in opioid-dependent pregnant women.
6. Opioid-dependent pregnant women are at risk of under-treatment of peripartum pain.
7. Breastfeeding should be encouraged in women who are stable on methadone maintenance treatment unless there are other medical contraindications.
8. The maternal methadone dose should be individually adjusted to control maternal craving or withdrawal symptoms.

(Suzi Lyons)

1. Institute of Obstetricians and Gynaecologists and Health Service Executive (2013) *Clinical practice guideline: methadone prescribing and administration in pregnancy*. Dublin: Institute of Obstetricians and Gynaecologists and Health Service Executive www.drugsandalcohol.ie/20188

Stakeholder views on housing-led services for homeless people

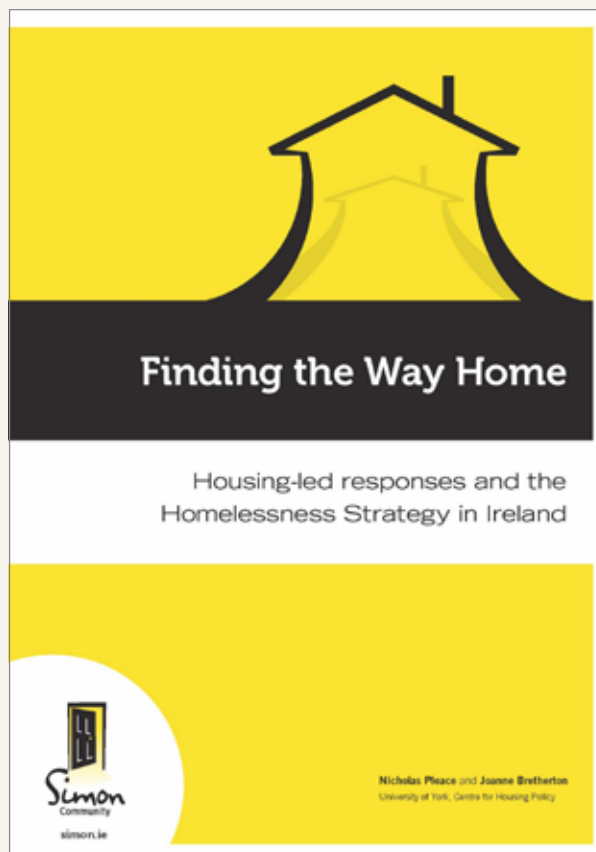
The Simon Community commissioned exploratory research to assess whether housing-led services would represent an improvement on existing practice in delivering services to homeless people in Ireland. The results of that research have now been published.¹ According to the authors, 'housing-led services are "housing-led" because the first thing they do is place a person who is homeless into permanent or settled accommodation and because the support they provide is mainly delivered within that accommodation. ...A housing-led service is also characterised by following a specific philosophy that promotes choice and control for people who are homeless' (p.8); and 'housing-led services follow a harm reduction approach with a recovery orientation' (p.9).

Fieldwork and data collection for this research included nine focus groups with 27 participants (21 males) who were or had recently been homeless, including 19 people who were or had been entrenched rough sleepers, i.e. people with high and multiple support needs who had sustained experience of sleeping rough. In addition, data were collected from 17 service providers working with the Simon Communities. Fieldwork with these groups was spread across Cork, Dublin, Dundalk, Letterkenny and Sligo. In addition, seven organisations working in the homeless sector responded to a detailed questionnaire. Emerging findings from all fieldwork and collation of data were discussed with participants from across government and the homeless sector prior to publication of the report.

Awareness of what the housing-led approach means was reported as high among service providers. Service users were not as aware of what the approach entailed, but, when it was explained, the idea of having their own 'home' was popular among them. There was consensus among service providers that simply providing housing to people with long histories of homelessness who might have high support needs, such as mental health and addiction issues, was unlikely to result in positive outcomes. Appropriate types and levels of support with housing were deemed to provide an effective response.

The main concern expressed by all participants was the insufficient supply of adequate and affordable housing for housing-led services to work effectively. Difficulty in accessing social housing due to a lack of new supply and barriers in the process of allocating the existing supply were cited as particular limitations.

Concerns were also expressed by all participants about the affordability of housing in the private rented sector. Restrictions on the amount paid to social welfare claimants through rent supplement meant that people were unable to meet the relatively high rents being charged in the private sector without having to 'top-up' from the remaining portion of their welfare payments. Also, the poor standard of some of the affordable private rented accommodation was cited as a concern. It was reported that some private landlords were reluctant to accommodate people with a history of homelessness as these people were perceived to be 'risky' tenants. In addition, in a social context where the need for private rented accommodation is growing among the general population, people with experience of homelessness are often the least preferred tenants by some private landlords.



People with experience of homelessness expressed a preference to be housed in social housing, which they believed provided more flexibility and stability in the longer term and was more suitable to their needs; this view was shared by service providers. These views are pertinent given that the housing-led approach is dependent, for the most part, on the immediate provision of a settled home in the community.

Some attractive features of the housing-led approach are that it offers people independence, choice and control to a greater extent than alternative models. Participants felt that while most people who become homeless in Ireland might wish to live independently in their own home with modest support, housing-led services were not the answer for people with high-support needs. Factors cited to elaborate on this view included a belief that some people who had experiences of long-term homelessness were also affected by their experiences in industrial schools, which in some cases led to them experiencing institutionalisation. It was felt, particularly by those with experience of homelessness that living independently without the appropriate level of support and access to meaningful daytime activities such as employment, training and education could lead to mental illness and/or relapse to problematic use of alcohol and drugs.

Joint working through case management to offer a package of supports is often seen as an integral part of delivering an effective housing-led model. The views expressed by service providers suggest that access to welfare benefits and to health and social services, as well as to specialist addiction

Housing-led services for homeless people (continued)

and mental health services, is currently restricted for people experiencing homelessness. These restrictions have arisen due to changes to the levels and eligibility rules for welfare benefits. Restricted access to health and other social services, primarily due to cuts in service provision, is seen to compromise efforts by the homeless sector to resettle homeless people; people with experience of homelessness and who are trying to live independently in the community are also adversely affected by these restrictions. Service providers also reported problems around mental health services not working with people with drug and alcohol problems and alcohol and drug services not working with people with mental health problems. These concerns regarding the fragmented nature of service provision may have implications for the inclusion of an integrated package of services for homeless people as part of the current Housing First Demonstration Project (HFDP) being operated in Dublin, as, 'all forms of housing-led services are reliant to at least some degree on joint working with the welfare systems and health, social care and mental health services' (p.27).

Service providers were sceptical of what they perceived as the official policy view, that housing-led services could be delivered as low-cost, low-intensity and short-term interventions to assist homeless people. On the contrary, they emphasised that the homeless population was not an homogenous group, rather homelessness was experienced by different people for different reasons and with different types and levels of support needs. There was consensus among service providers and homeless people that the sector needed to retain a broad mix of options to cater for the diverse needs of homeless people.

While the idea of housing-led services in Ireland was generally welcomed and endorsed by participants in this research, it is clear that from both standpoints, housing-led services are not currently seen as a panacea for the problem of homelessness and its associated issues. The reservations expressed by participants centre around the view that responses to homelessness involve more than just providing housing in the form of 'bricks and mortar'. Effective responses need to include housing alongside appropriate support, especially for people with high-support needs. In addition, participants in this research cautioned against providing housing as an individual unit of residence for some homeless people, instead it was suggested that communal residential housing with appropriate support might be more suitable for people with personal biographies that include sustained periods of time spent in institutions and homelessness. The divergent views expressed by participants in this exploratory study are not wholly different from the academic perspective which underpins a critical analysis of the suitability of the housing-led approach as a 'solution' to the often intractable problem that is homelessness. According to the authors, 'the consensus of the academic research is broadly similar – housing-led services are very effective at ending homelessness among people with high needs and sustained experience of homelessness, but that while some other gains in well-being are being achieved, these services are not necessarily fully meeting all associated support needs or successful with everyone they try to work with' (p.31).

(Martin Keane)

1. Pleave N and Bretherton J (2013) *Finding the way home: housing-led responses and the homelessness strategy in Ireland*. Dublin: Simon Communities of Ireland. www.drugsandalcohol.ie/20183

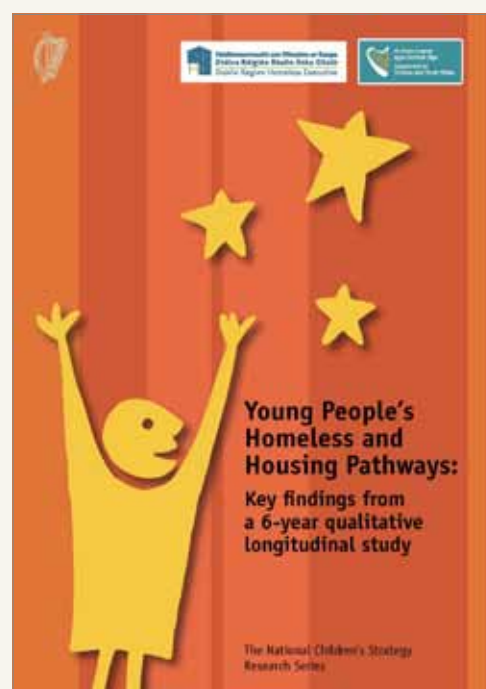
Youth homelessness in Dublin: key findings from a six-year study

Key findings from the only qualitative longitudinal study of youth homelessness undertaken in Ireland were published July 2013.¹ The study covered a six-year period and included three phases of data collection with young people experiencing homelessness in Dublin. Two earlier publications reported on phase 1 and phase 2,² and were covered in past issues of *Drugnet Ireland*.³ This article summarises the profile and characteristics of the participants and describes some of the key findings from the three phases, as reported in the latest publication.

Phase 1: Baseline profile and characteristics (September 2004 – January 2005)

Forty young people, 23 males and 17 females, aged between 14 and 22 years, were interviewed at baseline. Their early childhood was characterised by poverty, traumatic life events and household conflict and instability. They reported deteriorating relationships with their parents during their early to mid-teenage years. Eighteen of the 23 young men left school at or before the age of 15; the young women remained longer in education, with 11 of the 17 attending school at baseline interview.

Twenty-five of the young people were living in under-18s emergency or short-term hostel accommodation, and most of the others were accommodated in other short- or medium-term accommodation; three were in prison and two were sleeping rough. Eleven reported being homeless for between two and four years, and eight for five years or more.



Youth homelessness in Dublin (continued)

Those with longer homeless histories reported problematic and dependent patterns of alcohol and/or drug abuse, with half (13 males and 7 females) reporting use of heroin at some stage. 'Drug use escalated for practically all young people as their "careers" in homelessness progressed and this pattern of consumption was especially apparent among those who moved constantly between hostels targeting the under-18s' (p.22).

Twenty of the young men and eight of the young women had been charged with at least one criminal offence. According to the authors, 'their accounts demonstrate the interconnectedness of homeless, drug and criminal "careers"'. ...However, few of the young people were heavily involved in drug use and even fewer had records of offending at the time they first left home' (pp.22–23).

Becoming homeless

Almost half the 40 young people (9 males and 10 females) first experienced homelessness at age 14 or under, and 12 (9 males and 3 females) at age 15. Although most recalled their own unique account of becoming homeless, the authors identified three broad, and overlapping pathways that characterised their entry into homelessness:

- a history of state care;
- family instability and family conflict;
- problem behaviour and negative peer associations.

Sixteen of the young people had experience of the state care system, mainly through foster care, with many reported multiple placements leading to instability and disruption in their young lives. Although many experienced a traumatic childhood in the family home, this did not prevent them from carrying feelings of resentment about their separation from their parents and siblings.

For the majority of the young people, parental conflict and/or marital breakdown featured prominently in the events leading to their first homeless experience. Parental drug or alcohol abuse was reported by 16 and physical abuse by an adult in the home was experienced by 18 young people.

They also reported how their own behaviour, including using alcohol and drugs and staying out late with friends, often led to disagreement with their parents. Most of them admitted having been 'rebellious' in their early teens; however, for many the adverse circumstances of the family home contributed to their vulnerability. According to the authors,

Furthermore, by the time young people found themselves out of home for the first time, their experiences of a number of key institutions (including the family, school or State care) had been overwhelmingly negative. Consequently, at a relatively early age, a large number were living outside, or marginal to, the structures that play a critical role in preparing young people for the transition to adulthood. (p.24)

Phase 2: Homeless exits and continued homelessness (September 2005 – August 2006)

Thirty of the young people (16 males and 14 females) were re-interviewed at phase 2 of data collection. Seventeen (5 males and 12 females) had secured greater stability in their accommodation at this juncture, approximately 12–18 months since baseline. Seven were in transitional/ supported housing, six were living at home, three were in foster or residential state care and one was in private rented accommodation. Thirteen (11 male and 2 female) remained

homeless; five were in prison, four in adult hostels, two were sleeping rough, one was in a residential drug treatment programme and one was in temporary accommodation and awaiting sentencing in the criminal justice system. As these figures illustrate, a far greater number of female participants had exited homelessness by phase 2 of the study.

Phase 3: Sustained exits and prolonged homelessness (September 2009 – August 2010)

Twenty eight of the young people (15 males and 13 females) were re-interviewed at phase 3 of data collection. Fifteen (3 males and 12 females) had exited or sustained an exit from homelessness, of whom nine (including eight females) were living in the private rented sector, one male was in local authority housing, one female was living in an independent flat, one female was living in their partner's home, one female was in a residential aftercare facility and one female and one male were in the family home. As the authors point out: 'Consistent with the patterns identified at phase 2, far more females than males had exited or sustained an exit from homelessness. Gender therefore remains significant in the exiting patterns of young people...' (p.25).

This study has generated an in-depth and rich understanding of young people's routes into, through and out of homelessness. Its insights should provide food for thought for those charged with designing and implementing policy and practice to prevent youth homelessness. It is clear from the testimony of the participants that the key institutions of socialisation that we rely on to bring security, development and identity to our young people – the family, the education system and the state care apparatus – can fail miserably at times. When these institutions fail and young people end up homeless and vulnerable, measures to disrupt this experience and facilitate their quick exit from homelessness are key to their regaining stability. In this regard, the successful work done to ensure the exit from homelessness of all but one of the young women in this study has to be acknowledged. On the other hand, policy and practice also needs to acknowledge that it appears much harder for young men to exit homelessness and the longer they remain in this condition the more hazardous their lives become, i.e. criminal convictions and the more marginal they remain from society.

(Martin Keane)

1. Mayock P and Corr ML (2013) *Young people's homeless and housing pathways: key findings from a 6-year qualitative longitudinal study*. Dublin: Stationery Office. www.drugsandalcohol.ie/20191.
2. Mayock P and Vekic K (2006) *Understanding youth homelessness in Dublin city: key findings from the first phase of a longitudinal cohort study*. Dublin: Stationery Office. www.drugsandalcohol.ie/6200; and Mayock P, Corr ML and O'Sullivan E (2008) *Young people's homeless pathways*. Dublin: Homeless Agency. www.drugsandalcohol.ie/4239.
3. Keane M (2007) Research on youth homelessness in Dublin. *Drugnet Ireland*, (21): 21–22; and Keane M (2009) The process of youth homelessness. *Drugnet Ireland*, (29): 18.

Mapping the empirical research base of youth work: learning from international practice

An estimated 312,615 young people aged between 10 and 24 participated in youth work activities in Ireland during 2011, according to a recent report prepared for the National Youth Council (NYCI).¹ This figure represents 43.3% of this age cohort nationally; 54% of the participants were female and 53.3% were believed to be socially or economically disadvantaged.

Against this background, the first systematic map of youth work research internationally was published in June 2013.² This work was commissioned by the Department of Children and Youth Affairs to inform the development of a 'youth policy framework'. The report cites the EPPI-Centre's definition of a systematic map as 'a classification and description that aims primarily to illustrate the kinds of studies that exist' in a specific area (p.4). This article briefly describes the methods of the mapping process and the key elements of the design of youth work interventions.

Search strategy

Potential studies were drawn from 11 bibliographic databases, 10 relevant websites, contents pages of key journals, reference lists of systematic reviews, and input from key informants and experts. In total, 175 studies published between 1976 and 2011 are included in the final report; 69% of these are from the US.

Inclusion criteria

Studies were included if they focused on young people aged 10–24, professionals working with young people, or parents of young people engaged in youth work activities. Studies that focused on positive futures for young people, that reported evaluations of effectiveness, delivery and outcome measurement were included.

Profile of the 175 studies included

The majority (68%) of the 175 studies were published as peer-reviewed journal articles; 50% evaluated the impact of youth work programmes, focusing on 'what works', and 20% evaluated the process of delivering a programme, focusing on 'how it works'. One third were designed as case studies and 23% were cross-sectional designs; both approaches collected data at one point in time, e.g. following participation in programme activities. In addition to primary studies, 33 non-systematic and three systematic reviews were included. Methods of data collection used in the studies included interviews with individuals (41%), focus groups (17%), closed-question surveys (38%) and/or validated scales (21%), and observation of people and activities (19%). Some studies combined data collected by more than one method, e.g. interviews and surveys.

Theories, aims and activities of youth work

The most commonly cited theoretical approach among the 93 studies that evaluated outcomes was the 'positive youth development' theory. According to the authors, this school of thought asserts that 'for young people to meet developmental targets, they need to be engaged in activities delivered in settings that are safe, supportive and foster meaningful relationships. ...theories of positive youth development could underpin a range of different youth work activities and still be considered effective in producing desired outcomes' (p.23).

The next most commonly cited theoretical approaches underpinning youth work programme were the 'socio-ecological model' and the 'empowerment model'. The former model seeks to design programmes that address a combination of individual and environmental factors through focusing on the dynamic relationship between young people and others within the wider context of their lives. The latter model emphasises the design of programmes to assist young people to develop a greater understanding of power and control in their lives, socially, politically and economically, and to support them to become consciously and critically engaged with society through a range of measures and activities. Both models are more focused on desired outcomes for young people than on specific activities and both emphasise the interaction between young people and wider society. In contrast, the positive youth development model is more about creating the right conditions to improve personal development outcomes for young people.

The personal and social development of young people was reported as the primary aim in over twice as many included studies as any other aim (Table 1). In Ireland, the Youth Work Act 2001 defines youth work as:

A planned programme of education designed for the purpose of aiding and enhancing the personal and social development of young people through their voluntary involvement, and which is complementary to their formal, academic or vocational education and training and provided primarily by voluntary youth work organisations.

Leisure, recreation and arts activities were reported by most studies included in the mapping process (Table 1). The nature of youth work in Ireland is quite similar to that reported from international research, with the vast majority (80%) of youth work organisations in Ireland providing recreational, arts and sports-related activities.¹

Mapping the research base of youth work *(continued)*

Table 1 Aims and activities of youth work reported in 93 studies focusing on outcomes

Aims	Number of studies reporting as primary aim	Activities	Number of studies reporting activities
Personal and social development	71	Leisure and recreation	39
Social change	28	Arts, drama, music	28
Safety and well-being	26	Volunteer and service	26
Education and career	24	Sports	25
Contribution to society	20	Informal learning	22
		Social action	15
		Work	7

Source: Dickson *et al.* (2013)

Outcomes and measures in youth work

The NYCI report focused mainly on the impacts of youth work, specifically the economic benefits, i.e. crime reduction, rather than on outcomes and the outcome measures employed. However, the report listed (on p.91) some of the main outcomes of youth work highlighted in an earlier study,³ which are summarised below:

- enhanced personal attributes and qualities;
- opportunities for more positive associations with people;
- personal development;
- enhanced positive and pro-social behaviour;
- development of practical skills, for example making decisions, organising, planning; and
- information, advice and advocacy in relation to health, relationships, sexuality.

These outcomes are not dissimilar from those reported in international research and reflect the emphasis on improving personal and social development, which was reported in almost twice as many studies as other outcomes, such as improving civic engagement and reducing risky behaviour (Table 2).

Table 2 Outcomes and measures of youth work reported in 93 studies evaluating effectiveness in youth work

Outcomes*	Indicators	Number of studies
Relationship with others	Positive relationships with adults, peers; pro-social skills, leadership skills, decision-making skills, empowerment	66
Sense of self	Personal development, self-esteem, self-efficacy, self-confidence, identity	64
Community and society	Civic engagement, bonding with community, partnership working	36
Health and well-being	Reduced substance use, reduction of risky behaviours, making healthy choices, diverted from crime, positive mental health	36
Values and beliefs	Future aspirations, pro-social values, healthy attitudes	30
Formal education and training	Academic achievement, commitment to learning	27

* Outcomes are not mutually exclusive, reported overlap between studies

Source: Dickson *et al.* (2013)

This review of the literature shows that there are many similarities between the practice of youth work in Ireland and international research on the key components in design and evaluation. However, further work is needed to evaluate the outcomes of youth work in Ireland against international benchmarks and to assess the effectiveness of using generic youth work models, i.e. personal and social development, to target the most at-risk young people.

(Martin Keane)

1. Indecon International Economic Consultants (2012) *Assessment of the economic value of youth work*. Report prepared for the National Youth Council. Dublin: National Youth Council of Ireland. www.drugsandalcohol.ie/19045
2. Dickson K, Vigurs CA and Newman M (2013) *Youth work: a systematic map of the research literature*. Dublin: Department of Children and Youth Affairs. www.dcyia.gov.ie/viewdoc.asp?DocID=2720
3. Devlin M and Gunning A (2009) *The purpose and outcomes of youth work: report to the Interagency Group*. Dublin: Irish Youth Work Press. www.youthworkireland.ie/youth-work-centre/resources

Profile of attendees at MQI health promotion unit

Merchants Quay Ireland (MQI) has published the profile of a cohort of people attending its Health Promotion Unit (HPU) needle exchange.¹ The main objective of the HPU is to minimise the risks associated with injecting substances by providing sterile injecting equipment and information and instruction on safe injecting techniques. Data were collected from 338 attendees using an instrument developed specifically to meet the information needs of the HPU in MQI and included items from internationally validated survey instruments and items fashioned specifically for the present study. Staff in the HPU collected data on socio-demographic characteristics, substance use, injecting risk behaviour and blood-borne virus (BBV) status and treatment. This article presents some of the key findings in the report under the four domains of enquiry.

Socio-demographic characteristics

A total of 338 participants took part in the study, including 290 males (85.8%). Participants ranged in age from 20 to 59 years; the majority were in the 20–34-year age group. Participants included 19 different nationalities; the majority 297 (88%) were Irish nationals. Approximately a third of the cohort reported living in conditions which can be categorised as homeless (Table 1).



Table 1 Accommodation status during last seven days

Accommodation status	n	%
Own/rented home	160	47
Staying with friends/family	73	22
Emergency accommodation	67	20
Sleeping rough	15	4
Supported temporary accommodation	12	4
Long-term supported housing	11	3

Source: Jennings (2013)

Substance use

Participants who used heroin were found to consume an average of 2.35 bags per day, and to spend an average of €45.72 per day on the drug. Route of administration for the vast majority of heroin users was injecting, 245 (84.4%); 34 (11.7%) reported both injecting and/or smoking heroin and six (2.7%) reported smoking only.

There were no differences between the genders for most substances used. Where differences did arise, proportionately more females than males reported using prescribed methadone (73% v 46%), illicit benzodiazepines (25% v 17%) and prescribed benzodiazepines (23% v 14%) (Table 2).

Seventy-five per cent reported using two or more substances in the last month (current use). Thirty per cent (102) reported using two substances in the past month, the most frequent combination being heroin and methadone, used by 49 (48%) of the sub-sample. Almost 9 out of 10 users of prescribed methadone reported using heroin. Heroin users who did not report using methadone were reported to consume higher average amounts of heroin per day, to spend more money on heroin per day and to use heroin on the greatest number of days in the past month.

Profile of attendees at MQI (continued)

Table 2 Current use of substances reported by participants (N=338)

Substance used in past month	Males (n=290)		Females (n=48)	
	n	%	n	%
Heroin	249	86	41	85
Prescribed methadone	132	46	35	73
Cannabis	71	24	11	23
Alcohol	63	22	11	23
Illicit benzodiazepines	48	17	12	25
Prescribed benzodiazepines	42	14	11	23
Cocaine	25	9	0	0
Steroids	17	6	4	8
Mephedrone	16	6	5	10
Crack cocaine	16	6	4	8
Illicit methadone	7	2	1	2
Amphetamines	4	1	0	0
Other	7	2	6	13

Source: Jennings (2013)

Injecting risk behaviour

The report states that 329 (97%) of the cohort were currently injecting substances. Almost three quarters of the current injectors who provided a response reported that they had not shared injecting equipment or paraphernalia during the previous month. The most-used sites of injection reported were: the arm, 174 (53%), and the groin, 91 (28%), with 81 (25%) reporting using more than one site.

Table 3 gives the profile of the cohort in terms of blood-borne viral infection status, testing and treatment, as reported by the participants. Among those who tested positive for HIV (22), hepatitis C (125) and hepatitis B (12), uptake of treatment was poor, being as low as 14% in the case of hepatitis C. Of those who tested negative for any BBV, and who responded to the question, more than half had been tested within the past year. While reported co-infections for hepatitis B and C (3%) and HIV and hepatitis C (6%) were low, 73% of those who were HIV positive were also hepatitis C positive.

Table 3 Blood-borne viral infection: reported status, testing and treatment

	Tested	Positive	Receiving treatment	Negative	Time since last test taken by those with negative results		
					No. of responses	<1 year	>3 years
Total cohort	338 (100%)						
Tested for HIV	264 (78%)	22 (8%)	10 (45%)	234 (89%)	198	109 (55%)	25 (13%)
Tested for hepatitis C	278 (82%)	125 (45%)	18 (14%)	140 (50%)	112	70 (63%)	14 (12%)
Tested for hepatitis B	263 (78%)	12 (5%)	2 (17%)	241 (92%)	204	106 (52%)	32 (16%)
Tested for co-infections							
Hepatitis C and HIV	262 (78%)	15 (6%)					
Hep B and Hep C	262 (78%)	8 (3%)					
Hep B/Hep C/HIV	258 (76%)	1 (<1%)					

Source: Data from Jennings (2013)

The research group involved in this study make recommendations in three main areas:

- Policy – relating to needle exchange programmes, screening for BBVs, and ‘further consideration of safer injecting facilities in an Irish context ...in future national policy deliberations’.
- Research – relating to the specific needs of certain groups, including older, female and homeless users, polydrug users and steroid users, and the need for further research on needle-exchange services, serological testing and the management of hepatitis C.
- Practice – relating to improving service access and use by female and migrant drug users, familiarising staff with the profile of polydrug and steroid use, developing collaborative relationships with external agencies to improve uptake of BBV testing and treatment, encouraging safer injecting workshops, and, particularly in the case of drug users who are homeless, greater integration of voluntary and statutory services in a multi-disciplinary case management approach that is client-centred.

(Martin Keane)

1. Jennings CJ (2013) *Re-establishing contact: a profile of clients attending the Health Promotion Unit – needle exchange at Merchants Quay Ireland*. Dublin: Merchants Quay Ireland. www.drugsandalcohol.ie/19914

Report of the Inspector of Prisons

The Inspector of Prisons in his annual report for 2012 stated that the availability of drugs remains a major issue in a number of prisons.¹ In particular, he made reference to drug problems in Limerick Prison, a matter that was also raised by the Limerick Prison Visiting Committee in their annual report for 2012.² The Inspector also identified a number of issues of concern throughout the prison system, many of them drug-related. At present, for example, approximately 25% of Irish prisoners are in secure 23-hour lock-up for their own protection. This is often linked to threats from drug gangs in prison or because of drug debts owed to individuals or gangs. According to the Inspector's report:

The reasons why prisoners are on protection vary. In certain cases prisoners request that they wish to go on protection as they are either under direct threat from others in the prison or perceive that they are under threat. In other instances they are on protection simply because they come from a particular geographic area of the Country or because of their cultural ethnicity. The

prevalence of gangs in the prison, which reflects that which is on the outside, is also a problem as vulnerable prisoners can be forced to join a gang or do so of their own volition as they perceive that by doing this they are safer. (p.13)

One by-product of this prison reality is the undermining of drug service provision for dependent drug users in prison. The Inspector also points out that when prisoners are on 23-hour lock-up they effectively have little or no contact with teachers or addiction services.

(Johnny Connolly)

1. Reilly M (2013) *Office of the Inspector of Prisons annual report 2012*. Nenagh, Co Tipperary: Office of the Inspector of Prisons. www.drugsandalcohol.ie/20341
2. Limerick Prison Visiting Committee (2013) *Annual report 2012*. Dublin: Department of Justice and Equality. www.justice.ie/en/JELR/Pages/PB13000219

LRC calls for repeal of mandatory sentencing legislation in drug cases

The recent report published by the Law Reform Commission (LRC)¹ recommends that the presumptive sentencing regime for drug offences be repealed.² The Criminal Justice Act 1999 created a new offence of possessing controlled drugs having a value of £10,000 (€13,000) or more for sale or supply, which attracted a presumptive sentence of 10 years' imprisonment, except where there were 'exceptional and specific circumstances' relating to the offence, or to the person convicted of the offence. In an earlier consultation paper on the operation and impact of this legislation,³ the LRC called for a review of the sentencing regime, finding that in effect it had merely led to a 'bulge in the prison system comprising low-level drugs offenders' serving lengthy prison sentences (p.189). Following further examination, the LRC concludes in the present report that the legislation has not contributed to any reduction in levels of criminality, 'the paramount aim of the criminal justice system' (p.181).

This report reviews similar legislation in a number of other common law countries, noting that the enactment of presumptive minimum sentencing in Ireland was, to some extent, influenced by sentencing reforms in the US and the UK in particular. In the drugs context, a range of punitive sentencing measures has been introduced in other jurisdictions so as to reflect the relative seriousness of specific drug-related offences. Aggravating factors can include: repeat drug offences, dealing drugs to minors or 'with the aid or conspiring of a child under the age of 18 years' (p.155), drug trafficking while in possession of a firearm, selling drugs on a school bus or in the vicinity of a school, college, in a housing project, or to someone who is pregnant; running a drug trafficking enterprise or acting as the 'principal administrator, organiser or leader of a continuing criminal enterprise' (p.157) can also lead to more severe punishments. Aggravating factors may also relate to the quantity of drugs involved in the offence (p.161).

Although such a comparative analysis is of interest, the LRC cautions against relying too heavily on examples set by other countries, noting that these provisions 'are often the product of circumstances and cultural factors specific to the jurisdiction in question' (p.174). Ultimately, the LRC concludes, presumptive sentencing should be evaluated in terms of the extent to which it is consistent with the general aims of criminal sanctions, which include deterrence, punishment, reform, rehabilitation and reparation.⁴

Sections 4.191 to 4.197 of the report deal individually with these general aims (pp.174–176). In particular, the LRC observes that deterrence and punishment feature prominently as aims in respect of offences that attract presumptive sentences, as these sentences seek to

- (i) dissuade by coercive means, the offender from committing another drugs or firearms offence and to punish him or her severely for the offence that he or she has committed, and
- (ii) dissuade the public at large from committing the relevant drugs or firearms offences. (p.174)

With regard to deterrence, the LRC observes that, in practice, 'high-level [drug] offenders...shield themselves from detection and prosecution by means of complex and constantly evolving networks of distributors. It is unlikely that such offenders would be deterred by the prospect of a presumptive ...sentence when they are unlikely to be subjected to it'. At the other end of the scale, offenders are either 'low-level drug mules whose involvement in the drugs trade is generally secured by means of exploitation and/or coercion' or, referring to an observation of the Court of Criminal Appeal, 'they are themselves drug addicts struggling to escape from the terrors of their addiction'. Drug mules would be unlikely to be deterred by a presumptive sentence, in many cases either not being equipped to assess the legal

LRC calls for repeal of mandatory sentencing (*continued*)

consequences of their actions or fearing the consequences of refusing to carry drugs. Dependent drug users, on the other hand, are prepared to risk 'victimisation, overdose, the transmission of diseases, and toxicity and impurities in the drug in order to feed their addiction' and, as a consequence, according to the LRC, 'they are unlikely to be deterred by the prospect of lengthy imprisonment'.

With regard to meeting the aims of punishment from a retributive perspective, the LRC highlights the apparent injustice inherent in the legislation whereby the same presumptive sentencing regime applies to individuals regardless of their position in the drug trafficking operation and their consequent level of moral culpability. This arises because 'the market value of the drugs (€13,000 or more) ...is prioritised at the expense of other factors relevant to culpability, such as role, motive and state of mind of the offender'.

In calling for a repeal of the presumptive sentencing regime, the LRC concludes that the objective of reducing drug-related crime is unlikely to be achieved solely through criminal law enforcement, and that crime-reduction approaches must be informed by a deeper understanding of the complexity of the relationship between illicit drug use and crime and a focus on measures aimed at addressing drug dependency.⁵

(Johnny Connolly)

1. The Law Reform Commission is an independent statutory body established by the Law Reform Commission Act 1975. Its principal role is to keep the law under review and to make proposals for reform, in particular by recommending the enactment of legislation to clarify and modernise the law.
2. Law Reform Commission (2013) *Report: mandatory sentences*. LRC 108–2013. Dublin: LRC. www.drugsandalcohol.ie/20242. The LRC uses the term 'presumptive' as distinct from 'mandatory' in relation to sentences for certain drugs and firearms offences, in that there is a presumption that the sentence would apply unless the court deems otherwise in a specific case. The LRC distinguishes such sentences from mandatory life sentences for treason or capital murder, for example.
3. Law Reform Commission (2011) *Consultation paper: mandatory sentences*. LRC CP 66–2011. Dublin: LRC. www.drugsandalcohol.ie/16789. See also Connolly J (2012) Mandatory minimum sentencing. *Drugnet Ireland*, (41): 23–24. www.drugsandalcohol.ie/17288
4. See detailed discussion in chapter one of the LRC consultation paper.
5. With regard to the drugs–crime linkage, the LRC report endorses the analysis provided by the Health Research Board in an earlier study: Connolly J (2006) *Drugs and crime*. Overview 3. Dublin: Health Research Board. It also highlights the current focus by the British–Irish Council on recovery from drug dependence. See discussion pp.176–177.

Research on recidivism

The Probation Service and the Central Statistics Office (CSO) established a partnership to conduct research on recidivism and related issues among offenders on supervision in the community. The report was published in November 2012.¹ The first of its kind in Ireland, the study was based on anonymised offender and offence information relating to a 2007 cohort of offenders on the Probation Service supervision database. The study reports on recidivism within two years among that cohort, and on a four-year follow-up based on recorded crime and Court Service data held by the CSO. The study also examines variations in recidivism relating to type of original order, gender and age of the offender, category of original offence and of the subsequent offence.

The study provides an overview of community sanctions and their outcomes. The report lists some of its main findings:

- Almost 63% of offenders on Probation Service supervision had no conviction for a further offence committed within two years of the imposition of a Probation or Community Service order. The overall recidivism of offenders in the study was 37.2%.
- Reoffending was twice as likely to occur in the first rather than the second twelve months.
- The recidivism rate decreased as offender age increased.
- Male offenders represented 86% of the total population and had a higher recidivism rate than female offenders.
- Public Order was the most common original offence and these offenders had the highest recidivism rate.
- The three most common offences for which offenders were reconvicted were the same as the three most common original offences: Public Order, Theft and Drugs. (p.2)



The Irish Prison Service (IPS), in partnership with the CSO, also published a report on recidivism rates among ex-prisoners in Ireland.² The report, published in May 2013, is a study of recidivism among 7,701 prisoners released on completion of a sentence in 2007, using re-conviction data up to the end of 2010. The study also assesses variations in recidivism based on the age and gender of the offender, as well as the category of both the original and subsequent offences.

Research on recidivism (*continued*)

The IPS study is not comparable to the Probation study described on the previous page, which was based on a two-year period for reoffending and excluded a number of offence types. However, while the Probation study showed a recidivism rate of 37.2% within two years of the imposition of a probation or community service order, the IPS study showed a recidivism rate of 58.3% within two years of the completion of a prison sentence.

The IPS report sets out the findings of the study (pp.9–15), including the following:

- The overall recidivism rate of offenders within three years was 62.3%.
- Two thirds of re-offences occurred within six months of release. Over 80% of re-offending occurred within 12 months of release.
- Males made up 92% of the total population studied and had a higher recidivism rate than females (63% as opposed to 57%).
- The recidivism rate decreased as the offender age increased. While 68.5% of those under 21 years of age re-offended, the rate fell to 38.6% for the 51–60-year age group.
- The highest rate of recidivism was among those who had served a sentence for burglary and related offences (79.5%).
- The most common offence for which offenders were re-convicted was Public Order (1,281 or 27%).
- Almost 27% were reconvicted of the same offence; more than 34% of theft offenders committed a further theft offence.
- More than 20% of drug offenders committed a further drug offence.

The report concludes with the unsurprising observation:

For the majority of those incarcerated, similar criminogenic needs and risks exist. ...Lack of employment, abuse of alcohol and drugs, anti-social attitudes and companions, emotional and personal difficulties, poor educational achievement, family problems and lack of housing. (p.18)

The authors question whether it is reasonable, given the complexity of the problems many prisoners have, to expect the IPS or the criminal justice system to provide solutions in terms of reintegration. They conclude, 'If we are to really succeed in reconnecting offenders back to their communities, then we must devise a model which involves a multiplicity of state, community and voluntary agencies working in partnership on behalf of individual communities to bring about real change' (p. 19).

The IPS and the Probation Service, in partnership with the CSO, intend to jointly publish annual recidivism figures. Consistent with this new partnership approach, the services have agreed a joint service strategic plan for 2013–2015.³ Included in this are measures aimed at enhancing sentence management from pre- to post-imprisonment in a way which will 'facilitate improved prisoner outcomes', and at enhancing the roll-out of the Community Return scheme (p.3).

The Community Return scheme is a joint Probation Service and IPS initiative whereby selected prisoners are granted temporary release on condition they perform unpaid



supervised work in the community. Prisoners serving sentences of between one and eight years who have completed at least half their sentence are eligible. According to the 2012 annual report of the Probation Service⁴: 'A pilot programme commenced in October 2011 and a total of 365 offenders were released on to the scheme between that time and the end of 2012' (p.9). The scheme had a 90% compliance rate in 2012. By the end of 2012, 221 offenders had completed their allocated work, with approximately 10% (37) being returned to custody for non-compliance. The scheme involves a 'two-strike' rule whereby, if offenders fail to attend or are late for work on two separate occasions, they are regarded as in breach of the rules governing the scheme and are returned to custody to complete the entire balance of their sentence. According to the Probation Service 2012 annual report:⁴

The experience of all concerned has been very positive and many Community Return participants have been commended for their work ethic, punctuality and commitment. Initial feedback from the participants has also been positive with many commenting on the supports and structure it gives them on their release and how it has assisted in their transition back into the community. (p. 9)

(Johnny Connolly)

1. Probation Service (2012) *Probation Service recidivism study 2007–2011*. Dublin: Probation Service. www.drugsandalcohol.ie/20385
2. Irish Prison Service and Central Statistics Office (2013) *Irish Prison Service recidivism study 2013*. Dublin: Irish Prison Service. www.drugsandalcohol.ie/19942
3. Irish Prison Service and Probation Service (2013) *Joint Irish Prison Service & Probation Service strategic plan 2013–2015*. Longford: Irish Prison Service & Probation Service. www.drugsandalcohol.ie/19935
4. Probation Service (2013) *The Probation Service annual report 2012*. Dublin: Probation Service. www.drugsandalcohol.ie/19936

Penal reform high on the agenda

A report on penal reform by the Joint Oireachtas Committee on Justice, Defence and Equality¹ makes a number of recommendations aimed at reducing overcrowding in Irish prisons and promoting the development of effective alternatives to imprisonment. In October 2011, the Joint Committee established a sub-committee on penal reform, following publication of a report by the Thornton Hall Project Review Group.²

The Thornton Hall Group considered the application of alternatives to custody from both front-door and back-door perspectives. Front-door strategies involve reducing the numbers sent to prison, while back-door strategies involve some form of early release. The Group's report identifies (on p. 60) three forms of early release in Ireland:

- the government power to commute or remit any sentence under Article 13.6 of the Constitution;
- remission under the Prison Rules, which provide that prisoners can earn remission of up to 25% of their sentence; and
- temporary release, provided for under the Criminal Justice Act 1960 as amended by the Criminal Justice (Temporary Release of Prisoners) Act 2003.

The recommendations of the Joint Committee are aimed at enhancing these measures. Concerned about the 'significant increase over recent years in the number of prisoners in Ireland', the Committee called, in an overarching recommendation, for 'the adoption of a "decarceration strategy"; a declared intention by the Government to reduce the prison population by one-third over a ten-year period' (p.9). The Committee also recommended that all sentences of less than six months' imprisonment imposed in respect

of non-violent offences should be commuted and replaced with community service orders and that standard remission should be increased from one-quarter to one-third of all sentences over one month in length.

The Joint Committee also endorsed a recommendation made by the Irish Penal Reform Trust in its submission to the committee³ in calling for 'a single piece of legislation which would set out the basis for a structured release system; to include proposed changes to remission...temporary release and parole. ...for an expanded community return programme...[and to] underpin the strategies currently used by groups working with offenders post-release, and with potential offenders' (p.9). Finally, the Committee highlighted the need to address poor prison conditions and prison overcrowding and it called for an increase in the number of open prisons.

(Johnny Connolly)

1. Houses of the Oireachtas Joint Committee on Justice Defence and Equality (2013) *Report on penal reform*. Dublin: Houses of the Oireachtas. www.drugsandalcohol.ie/19618
2. The Thornton Hall Project Review Group was established in April 2011 by the Minister for Justice and Equality to review proposals of the previous government to build a large prison called Thornton Hall in County Dublin. See: Project Review Group (2011) *Report of the Thornton Hall Project Review Group*. Dublin: Department of Justice and Equality. www.justice.ie/en/JELR/Pages/ThorntonHallReviewRpt
3. The Irish Penal Reform Trust is Ireland's leading non-governmental organisation campaigning for the rights of people in prison and the progressive reform of Irish penal policy. See: Irish Penal Reform Trust (2012) *Reform of remission, temporary release and parole*. Dublin: Irish Penal Reform Trust. www.drugsandalcohol.ie/18656

Drug law enforcement and seizures

In a recent Dáil debate on Garda operations tabled by the Joint Oireachtas Committee on Justice, Defence and Equality, the Garda Commissioner stated that there are approximately 25 organised crime groups (OCGs) operating throughout the state.¹ The majority are centred in large urban areas such as Limerick, Cork, Galway, Sligo and Dublin. The Commissioner went on to say:

There is a high amount of interaction between the various organised crime groups throughout the country who regularly pursue joint enterprises, particularly drug imports. The vast majority of organised crime groups are drug trafficking groups... Each of these organised crime groups is structured hierarchically and would typically consist of a leadership, a number of middle-managers and low level criminals who could carry out day-to-day running of these organised crime groups. (p.4)

The 2012 annual report of the Garda Síochána² states that the Garda National Drugs Unit (GNDU) liaises with police forces in the UK, Spain, Holland and Belgium, 'where OCG's affecting the Irish jurisdiction tend to be the most proactive' (p.4). The GNDU has overall responsibility for drug law enforcement. In 2012, the GNDU arrested 125 people in connection with drug trafficking offences, 91 of whom were

charged and are currently before the courts. Seventy-one 'significant seizures' were made, including one in June 2012 of 432kg of cocaine with an estimated street value of €30.23 million, which was imported to Ireland from Bolivia via the Netherlands. Customs Drugs Law Enforcement and the US Drug Enforcement Administration were also involved in this operation. According to the 2012 annual report of the Revenue Commissioners, three members of an Irish OCG were arrested during this operation.³

Seizures of this size are, of course, untypical. The majority of drug seizures involve small amounts seized from individuals who possess the drugs for personal use. Drug seizures are primarily a reflection of law enforcement activity, with the number of seizures in any given period affected by such factors as law enforcement resources, strategies and priorities, and by the vulnerability of traffickers to those activities. However, drug seizure trends can also provide an indirect indicator of the supply and availability of drugs.

Cannabis seizures account for the largest proportion of all drugs seized. Figure 1 shows trends in cannabis-related seizures and total seizures between 2003 and 2012. The total number of drug seizures increased from 5,299 in 2004 to a peak of 10,444 in 2007. Between 2008 and 2010 the number almost halved, to 5,477. This decrease can be

Drug law enforcement (continued)

explained primarily by the significant decrease in cannabis-type substances seized. Although not all drugs seized by law enforcement are necessarily analysed and reported by the Forensic Science Laboratory, it is difficult to know if the reduction in cannabis-related seizures reflects a decline in cannabis use or a reduction in law enforcement activity. Following a slight increase in 2011, the number of cannabis seizures again decreased slightly in 2012.

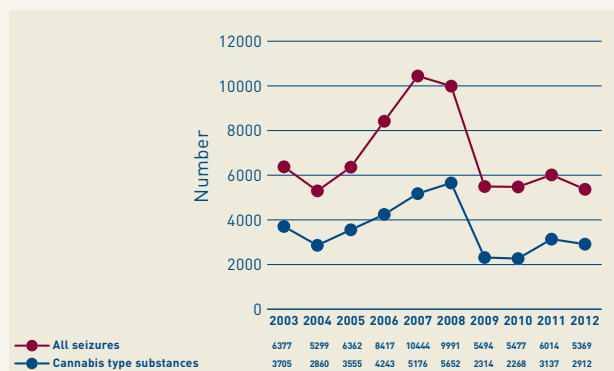


Figure 1 Trends in total drug seizures and cannabis seizures, 2003–2012

Source: Central Statistics Office unpublished data

The decrease in cannabis seizures between 2008 and 2010 may also be partly explained by a change in the nature of cannabis use, with people moving from resin to more potent forms of cannabis, such as herbal cannabis. For example, Figure 2 shows that although seizures of cannabis resin have decreased significantly since 2006, seizures of cannabis plants have increased steadily since then, with a slight decrease in 2012. Herbal cannabis seizures almost doubled between 2009 and 2011, from 981 to 1,833 in 2011, and then levelled off in 2012.

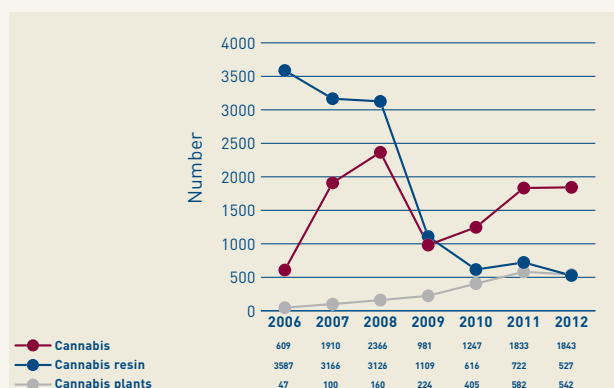


Figure 2 Trends in drug seizures by cannabis type, 2006–2012

Source: Central Statistics Office unpublished data

The reduction in the total number of reported seizures since 2007 shown in Figure 1 may also be explained by a reduction in the number of seizures of other drugs. Figure 3 shows trends in seizures for a selection of drugs, excluding cannabis, between 2003 and 2012. There was a significant decline in seizures of cocaine and heroin between 2007 and 2011. In 2012, heroin seizures increased slightly, while cocaine seizures continued to decrease. Seizures of ecstasy-type substances also decreased significantly between 2007 and 2010. However, in 2011, they increased by more than 800%. This upward pattern continued, albeit by a small margin, in 2012.

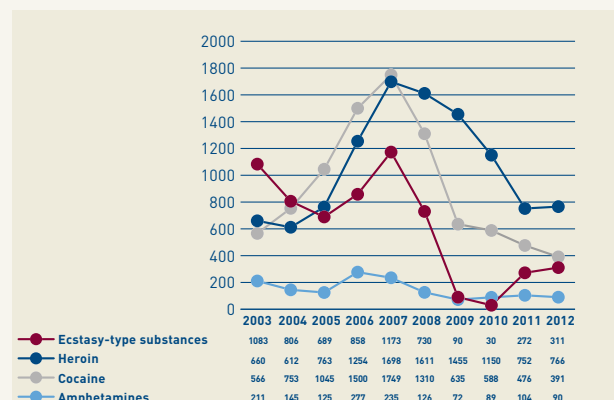


Figure 3 Trends in seizures of selected drugs, excluding cannabis, 2003–2012

Source: Central Statistics Office unpublished data

(Johnny Connolly)

1. Callinan M (2012, 21 November) *Parliamentary Debates Dáil Éireann (Official report: unrevised): Joint Committee on Justice, Defence and Equality debate*. Garda operations: discussion with An Garda Síochána. www.drugsandalcohol.ie/20352
2. An Garda Síochána (2013) *An Garda Síochána: annual report 2012*. Dublin, An Garda Síochána. www.drugsandalcohol.ie/20365
3. Revenue Commissioners (2013) *Annual report 2012*. Dublin: Revenue Commissioners, p.46. www.revenue.ie/en/about/publications/annual-reports/2012/downloads.html

From Drugnet Europe

Health and social responses profiles

Cited from *Drugnet Europe*, No. 82, April–June 2013

How are countries in Europe responding to drug use in the areas of treatment, harm reduction, social reintegration and the prison environment? The EMCDDA's country-by-country *Health and social responses profiles* (HSRs) aim to answer this question. The profiles include interactive maps and timelines showing the year in which key treatment and harm reduction measures were introduced in Europe. Also included are key source data and a glossary of terms. Available at www.emcdda.europa.eu/countries/hsr-profiles

Perspectives on drugs

Cited from *Drugnet Europe*, No. 82, April–June 2013

The EMCDDA's new Perspectives on drugs (PODs) are online analyses providing insights into a selection of important issues. Eleven PODs were released alongside the European Drug Report, covering as many issues, including: new treatment approaches for hepatitis C; high-risk cannabis use; cocaine-related emergencies; and the control of increasingly available new psychoactive substances. The PODs, which incorporate video and interactive features, offer key content in user-friendly summaries downloadable in pdf. Available at www.emcdda.europa.eu/topics/pods

Misuse of medicines in the EU

Cited from *Drugnet Europe*, No. 83, July–September 2013

The misuse of medicines in Europe is an issue of growing concern. With studies revealing that analgesics, sedatives/hypnotics and opioid substitution medicines are being consumed in ways other than those medically intended, this phenomenon merits greater awareness.

In order to assess the severity and magnitude of the problem, experts from the EMCDDA and the German national focal point (IFT) carried out a systematic review of the literature on the misuse of these drugs (with the exception of benzodiazepines).¹ Relevant literature was identified between 2001 and 2011. The results show that the main groups of misused medicines include opioid analgesics, methadone, buprenorphine and the so-called Z-drugs (e.g. zopiclone, zaleplon, zolpidem). Regional trends in medicine misuse indicate heterogeneity across the EU with respect to misused medicine types and research activities. Prevalence, high-risk populations and factors contributing to medicine misuse are discussed in the review, as are the implications of the findings for prevention, treatment and policy in the EU.

1. Casati, A, Sedefov R and Pfeiffer-Gerschel T (2012) Misuse of medicines in the European Union: a systematic review of the literature. *European Addiction Research*, 18(5): 228–245.

New report reveals how a better understanding of the science of addiction can improve our response to drug problems

Cited from *Drugnet Europe*, No. 83, July–September 2013

Designed to encourage debate and promote understanding of the concept, [a new report from the EMCDDA] *Models of addiction*¹ provides a critical review of existing addiction theories and explores how these can be organised into an overarching structure to inform how we assess, prevent and treat addictive behaviours. This is not limited to the traditional illicit drugs of abuse, but also covers alcohol and

tobacco use and even non-pharmacological addictions, such as gambling or compulsive use of the Internet.

The new report shows that there is no single model of addiction but competing perspectives sharing common elements. With this peer-reviewed analysis, the EMCDDA supports drug policy by providing a broad definition of the term, covering substance-based and behavioural addiction and reflecting current scientific developments.

An essential take-home message from the analysis is that, whilst there are advantages to be drawn from our growing understanding of the biological basis of addiction (e.g. 'brain disease' model), it is not helpful to be over reductive. The report argues that understanding the broader social and psychological aspects of addictive behaviour can also be important for successful prevention and treatment responses. It provides a basis for a more comprehensive and structured approach to developing responses and highlights the need to draw on a pool of interventions (education, persuasion, training).

1. West R (2013) *Models of addiction*. EMCDDA Insights Series No. 14. Luxembourg: Publications Office of the European Union. www.emcdda.europa.eu/publications/insights/models-addiction

Drugnet Europe is the quarterly newsletter of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). *Drugs in focus* is a series of policy briefings published by the EMCDDA. Both publications are available at www.emcdda.europa.eu.

If you would like a hard copy of the current or future issues of either publication, please contact:

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42–47 Lower Mount Street, Dublin 2.

Tel: 01 2345 148; Email: drugnet@hrb.ie

Recent publications

Journal articles

The following abstracts are cited from recently published journal articles relating to the drugs situation in Ireland.

Onset of cocaine use: associated alcohol intoxication and psychosocial characteristics among adolescents in substance abuse treatment

Apantaku-Olajide T, Darker CD and Smyth BP

Journal of Addiction Medicine, 2013, 7(3): 183–188.

www.drugsandalcohol.ie/20340

Objectives: Cocaine abuse is widespread in Europe, and Ireland ranks among the leading countries for prevalence of cocaine use among adolescents. This study aimed to examine demographic and substance use correlates of lifetime cocaine use among adolescents with substance use disorder, and to explore the relationship between alcohol intoxication and cocaine initiation.

Methods: Data from a cross-sectional study of 171 adolescents presenting to an outpatient substance abuse treatment program in the Dublin metropolitan area were analyzed. Bivariate and multivariate analyses were conducted.

Results: Approximately 64% of the participants reported ever having used cocaine: 70% reported the first use of cocaine was while alcohol intoxicated and 96% reported the onset of cocaine use was preceded by cannabis use. Later age at treatment entry, unstable accommodation, non engagement in educational/vocational functions, and greater frequency of alcohol and cannabis use had robust associations with lifetime cocaine use. Male gender was significantly associated with first use of cocaine while alcohol intoxicated.

Conclusions: Alcohol frequently plays a central role in cocaine initiation in Irish adolescents. Efforts to delay, avoid, or reduce adolescent drinking may yield benefits in terms of reducing cocaine use initiation in this population.

A qualitative study of prescribing doctor experiences of methadone maintenance treatment

Van Hout MC and Bingham T

International Journal of Mental Health and Addiction, 2013, 25 April, Early online.

www.drugsandalcohol.ie/20262

Methadone maintenance treatment (MMT) is recognized as an effective treatment for opiate dependence. It is provided in Ireland in addiction clinics and for stabilized patients in primary care. The aim of the study was to explore doctor's experiences of methadone prescribing, therapeutic alliance and methadone treatment pathways. Semi structured interviews were conducted with a convenience sample of prescribing doctors (n=16). Thematic analysis of narratives was undertaken. Observations around MMT were positive in reducing harm associated with injecting drug use and opiate dependence, and represented an important turning point for patients. Doctor efforts to assist their patients were grounded in positive, empathic relationships. Some concerns were relayed with regard to prescribing restrictions. Participants commented on the need for policy makers to consider the expansion of MMT provision to include alternative pharmacological approaches, improved interagency, psychosocial and detoxification supports, community based nurse prescribing and adjunct treatment for polydrug and alcohol use.

Miaow miaow: a review of the new psychoactive drug mephedrone

Brennan R and Van Hout MC

Drugs and Alcohol Today, 2012, 12(4): 241–253.

www.drugsandalcohol.ie/20261

Mephedrone is a synthetic stimulant drug causing entactogenic and hallucinogenic effects. A systematic review of all existing empirical research and literature from 2009 to 2012 on this new psychoactive drug was conducted. This paper aims to report on that review. The search was restricted to publications from 2009 to 2012, and produced 702 results; 598 results were discarded, with 104 deemed suitable for inclusion.

The review underscores mephedrone's popularity despite legislative controls. Drug displacement patterns from illicit to licit were observed prior to controls, with blending of mephedrone and other substitute cathinones with street drugs thereafter. User consumptive choices are grounded in availability, perceptions of legality and safety, curiosity and perceived quality of drug outcomes within poly drug taking repertoires. Clinical reports indicate that mephedrone has high abuse potential and toxicity, with several dependence symptoms. Risk assessment, detection, diagnosis and treatment of mephedrone use are difficult due to polydrug use and associated mental health disorders. The review points to the need for further research into the pharmacology and toxicity of mephedrone in order to better equip clinicians with assessment, diagnosis and treatment strategies to reduce morbidity.

Methadone, codeine and acute haemorrhagic necrotising pancreatitis: which came first?

Tormey WP, Sabah M and Moore TM

Forensic Science International, 2013, 226(1–3): e52–53.

www.drugsandalcohol.ie/20240

Acute haemorrhagic necrotising pancreatitis led to the death at home of a young female who was on a methadone maintenance programme. Toxic levels of codeine with potentially lethal levels of methadone and morphine were found at post-mortem. Whether opiates caused the pancreatitis or were the consequence of self-medication for pain is impossible to differentiate. Forensic toxicology may pose the question but be unable to provide the answer.

Teachers' perspectives on their role in school-based alcohol and cannabis prevention

Van Hout MC, Foley M, McCormack A and Tardif E

International Journal of Health Promotion and Education, 2012, 50(6): 328–341.

www.drugsandalcohol.ie/20235

Schools are an important setting for the implementation of health education and harm prevention initiatives.

The research aimed to investigate teachers' perspectives in Ireland on their role and that of the school in the delivery of school-based alcohol and cannabis education–prevention. Irish school-based drug education–prevention is currently provided within the remit of the Social Personal Health Education (SPHE) module. Thirteen second-level schools took part in the research. A questionnaire collected information on teachers' experiences of student alcohol and cannabis use, attitudes toward teacher and school prevention roles, and levels of school satisfaction (n = 131). The results indicated that teachers' experiences of effects of student alcohol and cannabis use in school were rare. Over half of teachers had never taken part in education or prevention activities, with SPHE teachers more likely to do so and report a positive attitude toward such activities. Teacher levels of satisfaction with their school were positively correlated

Recent publications (continued)

with attitude toward the teacher and school's role in alcohol and cannabis education–prevention. High awareness of school drug and alcohol policies was recorded, along with the need for training, support, and information for all teachers. The findings underscore the need for 'whole school' integrated approaches involving a shared organisation-wide approach to student substance education–prevention.

Using chi-Squared Automatic Interaction Detection (CHAID) modelling to identify groups of methadone treatment clients experiencing significantly poorer treatment outcomes

Murphy E and Comiskey C

Journal of Substance Abuse Treatment, 2013, 45(4): 343–349.

www.drugsandalcohol.ie/20187

In times of scarce resources it is important for services to make evidence based decisions when identifying clients with poor outcomes. Chi-Squared Automatic Interaction Detection (CHAID) modelling was used to identify characteristics of clients experiencing statistically significant poor outcomes. A national, longitudinal study recruited and interviewed, using the Maudsley Addiction Profile (MAP), 215 clients starting methadone treatment and 78% were interviewed one year later. Four CHAID analyses were conducted to model the interactions between the primary outcome variable, used heroin in the last 90 days prior to one year interview and variables on drug use, treatment history, social functioning and demographics. Results revealed that regardless of these other variables, males over 22 years of age consistently demonstrated significantly poorer outcomes than all other clients. CHAID models can be easily applied by service providers to provide ongoing evidence on clients exhibiting poor outcomes and requiring priority within services.

Problem alcohol use among problem drug users: development and content of clinical guidelines for general practice

Klimas J, Cullen W and Field CA

Irish Journal of Medical Science, 2013, 3 July, Early online.

www.drugsandalcohol.ie/20158

Problem alcohol use is common and associated with considerable adverse outcomes among patients who attend primary care in Ireland and other European countries for opiate substitution treatment. This paper aims to describe the development and content of clinical guidelines for the management of problem alcohol use among this population.

The guidelines were developed in three stages: (1) identification of key stakeholders, (2) development of evidence-based draft guidelines, and (3) determination of a modified 'Delphi-facilitated' consensus among the group members. They incorporate advice on all aspects of care, including (1) definition of problem alcohol use among problem drug users, (2) alcohol screening, (3) brief intervention, and (4) subsequent management of patients with alcohol dependence. The researchers concluded that primary care has an important role to play in the care of problem alcohol use among problem drug users, especially opiate substitution patients. Further research on strategies to inform the implementation of these guidelines is a priority.

Problem alcohol use among problem drug users in primary care: a qualitative study of what patients think about screening and treatment

Field CA, Klimas J, Barry J *et al.*

BMC Family Practice, 2013, 14:98

www.drugsandalcohol.ie/20447

Background: Problem alcohol use is common and associated with considerable adverse outcomes among patients who attend primary care in Ireland and other European countries for opiate substitution treatment. This paper aims to describe patients' experience of, and attitude towards, screening and therapeutic interventions for problem alcohol use in primary care.

Methods: This qualitative study recruited problem drug users (N=28) from primary care based methadone programmes in the Ireland's Eastern region, using a stratified sampling matrix to include size of general practice and geographical area. Semi-structured interviews were conducted and analysed using thematic analysis, and audited by a third reviewer.

Results: We identified three overarching themes relevant to the purpose of this paper: (1) patients' experience of, and (2) attitude towards, screening and treatment for problem alcohol use in primary care, as well as their (3) views on service improvement. While most patients reported being screened for problem alcohol use at initial assessment, few recalled routine screening or treatment. Among the barriers and enablers to screening and treatment, patients highlighted the importance of the practitioner-patient relationship in helping them address the issue. Nevertheless, patients felt that healthcare professionals should be more proactive in the management of problem alcohol use at a primary care level and that primary care can play an important role in their treatment.

Conclusions: Problem alcohol use is an important challenge in the care of problem drug users. While primary care is well placed to address this issue, little data has reported on this topic. The development of interventions which promote screening and brief interventions in practice are likely to benefit this at-risk group and further research and education, that help achieve this goal, are a priority. Strategies such as dissemination of clinical guidelines, educational videos, academic detailing and practice visits, should be explored.

Substance use in young persons in Ireland, a systematic review

Murphy K, Sahm L, Lambert S and Byrne S

Addictive Behaviors, 2013, 38(8): 2392–2401.

www.drugsandalcohol.ie/19669

Adolescence is a time of physical and mental development when small changes can impact on the rest of a person's life. Substance use in this crucial period can have long-lasting consequences for the individual and for society. The prevalence of substance use in young people is an area of concern for policy makers and health workers. This systematic review looked at prevalence for four substances, alcohol, tobacco, cannabis, and benzodiazepines, across the Republic of Ireland for persons between the ages of 13 and 24, and compared usage between 2000 and 2012. Eighteen articles were included in the review. It was seen that tobacco, alcohol, and cannabis use has fallen in the lifetime and previous month use. The level of benzodiazepine use has remained similar in the period of study. Future work should redress the imbalance in substance use research that sees the majority of researchers looking at a few substances while little work is done on the others.

Upcoming events

(Compiled by Joan Moore – jmoore@hrb.ie)

October

10 October 2013

Drugs and alcohol in the workplace – assessment, treatment and rehabilitation 34th annual EAP conference

Venue: Ashling Hotel, Parkgate Street, Dublin 8

Organised by / Contact: EAP Institute

Email: anita@eapinstitute.com

Web: www.eapinstitute.com/conference13/conference.asp

Information: This conference will feature presentations from HR managers, medical specialists, experts in toxicology and laboratory drug testing, EAP consultants and community based support groups on resources available to those in the workplace who may require assessment, treatment and rehabilitation. The invited speakers are: Prof Aidan McCormick, St Vincent's Hospital; Pat Ward, head of corporate services, Dublin Port Company; Maurice Quinlan, director of the EAP Institute; Dr Mark Piper, toxicology manager, Randox Testing Services; Invited speakers from Alcoholics Anonymous, Narcotics Anonymous and Al-Anon Family Services. Session chairs are Frank Cunneen, IBEC, and Alan Moran, Hibernian Healthcare.

10 October 2013

Drugs & Alcohol – over the counter, under the net One-day training course

Venue: Easton Business Centre, Bristol BS5 0HE

Organised by / Contact: The Training Exchange

Email: info@trainingexchange.org.uk

Web: <http://tinyurl.com/blo4fry>

Information: Drugs bought over the counter in chemists and via the internet are now commonplace. But what kind of a problem are they? Explore the changing face of drug-using culture, the commercialisation of medications, and the revolutionary impact of the internet and how it is policed. This course provides opportunities to identify the drugs available, how much we know about them, their effects and risks; and to consider how we can work effectively with people to reduce harm and support recovery. Trainer – Rowan Miller.

19 October 2013

Family Support Network annual work conference

Venue: Citywest Hotel, Saggart, Co Dublin

Organised by / Contact: Family Support Network

Email: info@fsn.ie

Web: www.fsn.ie/news_events/index.html

Information: The National Family Support Network is an autonomous self-help organisation that respects the lived experiences of families affected by drugs in a welcoming non-judgemental atmosphere. The Annual Work Conference provides family support groups with the opportunity to discuss national policy and to participate in training workshops. See our website for more information on cost and what is included. Full payment along with completed booking form must be submitted to the NFSN by 20th September 2013 to guarantee your place.

November

7 November 2013

Pathways through prostitution: Exploring positive support models for women affected by prostitution and sex trafficking

Venue: Morrison Hotel, Ormond Quay Lower, Dublin 1

Organised by / Contact: Ruhama

Email: admin@ruhama.ie

Web: www.ruhama.ie/index.php

Information: This free half-day event will host presentations and sessions featuring: international research on exiting prostitution and recovery from sex trafficking; Ruhama's model of work with women in Ireland; current trends, challenges and good practice responses; personal perspectives and needs of survivors; facilitated discussion. Full details of speakers will be posted on our website in due course. This event will be of interest to members of organisations working with vulnerable women, providers of migrant support, addiction and homeless services, and health, legal and law enforcement professionals. Registration is essential and numbers are strictly limited.

7–8 November 2013

SSA Annual Symposium 2013

Venue: Park Inn Hotel, York, UK

Organised by / Contact: DrugScope

Email: Society for the Study of Addiction

Web: www.addiction-ssa.org/ssa_10.htm

Information: Professor Robert West will give the Society lecture: 'What can the experience of combating tobacco addiction globally tell us about better ways of addressing other addictions?' Themes of the symposium will be: patient/service-user involvement; effective mechanisms of treatment; alcohol and drug testing methods and their uses; international treatment and prevention policy. The winner of the SSA Fred Yates prize 2013, Jaime Delgadillo, will talk on his work, 'Mental health screening and outcome measurement in alcohol and drug users'.

11–16 November 2013

Drug and Alcohol Awareness Week

Organised by / Contact: Midland Regional Drugs Task Force

Email: mrdtf@hse.ie

Web: www.mrdtf.ie/news-details.php?ID=24

Information: Details will be posted on the MRDTF website in due course.

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